

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24001

| | | | | | | | | | | | | |
|--|---|--|---|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Alberta McRae | | | | 2. Date of Death Month Day Year July 25, 1999 | | | | 3. Time of Death 11:43 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) 1113 N. Milton Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death Baltimore City | | | |
| Funeral Director | 5. Social Security Number 216-34-6629 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) March 14, 1933 | | 9. Birthplace (State or Foreign Country) North Carolina | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Baltimore City | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 1113 N. Milton Avenue | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? United States | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: African American | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | | 16b. Kind of Business/Industry Private Sector | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) William Ingram | | | | 18. Mother's Name (First, Middle, Maiden Surname) Della Little | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Bishop LeRoy McRae | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1113 N. Milton Avenue, Baltimore, MD 21213 | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | Date 7/31/99 | | 20c. Location - City or Town, State Baltimore, MD | | | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Loudon Park Funeral Home, 3620 Wilkens Avenue Baltimore, Maryland 21229 | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Immediate Cause (Final disease or condition resulting in death) | | a. <i>Congestive Heart Failure</i> Due to (or as a consequence of): | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. <i>Hypertensive Heart Disease</i> Due to (or as a consequence of): | | | | | | | | | |
| | | | c. Due to (or as a consequence of): | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21260 | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>[Signature]</i> MD | | | | 29c. License number DB2975 | | 29d. Date signed (Month, Day, Year) 7-29-99 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. RAMAIAH MD 447 N. Kenwood Ave. BALTIMORE 21224 | | | | | | | | | | | |
| 7178 | 31. Date filed (Month, Day, Year) JUL 30 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24002

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Petrie Minty

2. Date of Death

Month Day Year
July 29, 1999

3. Time of Death

2:00 PM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

311-20-8709

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB 25, 1924

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

White Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2600 Meredith Road

10f. Zip Code

21161

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Harry Petrie

18. Mother's Name (First, Middle, Maiden Surname)

Rubie Hayhurst

19a. Informant's Name/Relationship (Type, Print)

Susan Minty-Riehm/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2600 Meredith Road White Hall, MD 21161

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 7/30/99 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. idiopathic pulmonary fibrosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W.A. Riley, M.D.

29c. License number

D25205

29d. Date signed (Month, Day, Year)

July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley, M.D. 6701 M. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

B. Sparks

State
Registrar

MINTY, PATRICIA 7-29-99
Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24003

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|----------------------------------|---|--------------------------------|---|--|---|----|---------------|----------------------------------|--|----|--------------------------|----------------------------------|--|----|-------------------------------------|----------------------------------|--|----|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VIRGINIA MYERS | | | 2. Date of Death Month JULY Day 20 Year 1999 | | 3. Time of Death 1925 | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 230-03-9736 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 22, 1918 | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Virginia | | | | | | | | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Saint Marys | | 10c. City, Town or Location Mechanicsville | | 10d. Inside City Limits 1 Yes 2 No | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 511 Redgate Drive | | | | 10f. Zip Code 20659 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Shields Curtis Radcliffe | | | | 18. Mother's Name (First, Middle, Maiden Surname) Zora Mae Lovell | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Norman Wayne Myers/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Redgate Drive, Mechanicsville, MD 20659 | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Sepsis</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Gangrene Rt Foot.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Peripheral Vascular disease.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Sepsis | Due to (or as a consequence of): | | b. | Gangrene Rt Foot. | Due to (or as a consequence of): | | c. | Peripheral Vascular disease. | Due to (or as a consequence of): | | d. | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. | Sepsis | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | |
| | b. | Gangrene Rt Foot. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | |
| | c. | Peripheral Vascular disease. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, Respiratory Failure Diabetes Mellitus. | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Zahir Yousaf | | | | 29c. License number D27189 | | 29d. Date signed (Month, Day, Year) 7/22/99 | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Zahir Yousaf, M.D., Prince Frederick, Maryland 20678 | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

مجلس شورای ملی

لایحه تصویب

در باب...

مجلس شورای ملی

تاریخ...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24004

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM MOORE | | | | 2. Date of Death Month 07 Day 25 Year 99 | | 3. Time of Death 1757 | |
| | 4e. Facility Name (If not institution, give street and number) UNIV. OF MARYLAND | | | | 4b. City, Town, or Location of Death BALT. | | 4c. County of Death BALT. | |
| Funeral Director | 5. Social Security Number 2860 6626 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 46 Yrs. | | If Under 1 Year Months Days | |
| | Usual Residence of Decedent | | 10a. State MARYLAND | | 10b. County n/A | | 10c. City, Town or Location BALTIMORE | |
| 10e. Street and Number 601 S. LIGHT STREET | | 10f. Zip Code 21202 | | 10g. Citizen of What Country? U.S.A. | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: AFRO-american | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (14 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK | | 16b. Kind of Business/Industry SOCIAL SECURITY | | | | |
| 17. Father's Name (First, Middle, Last) WILBERT THOMPSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA MOORE | | | | |
| 19e. Informant's Name/Relationship (Type, Print) ANNA MOORE / MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3538 PELHAM AVE BALTO, MD. 21213 | | | | |
| 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Location - City or Town, State july 31, 1999 BALTO, MD. | | 20d. Date | | |
| 21. Signature of Funeral Service Licensee <i>Patricia Batts</i> | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. CVA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Michael A. Kolnick | | | | 29c. License number D 41396 | | 29d. Date signed (Month, Day, Year) 7/25/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Kolnick UNIV. OF MARYLAND Hospital | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature <i>James G. Sparks</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24005

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank A. Manfra, Sr.

2. Date of Death

Month 7-26-99 Year

3. Time of Death

9:00am

4a. Facility Name (If not institution, give street and number)

Hopkins Bayview

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

100-16-8367

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year) 8-3-22

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10e. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

320 Kane Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No WW2

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Structural Steel

16b. Kind of Business/Industry

Union

17. Father's Name (First, Middle, Last)

Olderico Manfra

18. Mother's Name (First, Middle, Maiden Surname)

Jennifer Tirelli

19a. Informant's Name/Relationship (Type, Print)

Mrs. Bernice Manfra

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

320 Kane Street Balto., MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Stanislaus

Date

7-29-99

20c. Location - City or Town, State

Balto., MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kaczorowski Funeral Home

1201 Dundalk Avenue Baltimore, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42232

29d. Date signed (Month, Day, Year)

7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2112 Dundalk Ave Baltimore MD 21222

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24006

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SOPHIA S. MAZUREK

2. Date of Death

Month Day Year
JULY 25, 1999

3. Time of Death

4a. Facility Name (If not institution, give street and number)

FUTURE CARE CANTON HARBOR

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-09-4983

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9/13/13

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

632 S. POTOMAC STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

WOJCIECH BANACHOWSKI

18. Mother's Name (First, Middle, Maiden Surname)

TEKLA ZARZYCKA

19a. Informant's Name/Relationship (Type, Print)

MISS MARLENE MAZUREK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

632 S. POTOMAC ST. BALTIMORE, MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ST. STANISLAUS CEME.

Date

7/28/99

20c. Location - City or Town, State

BALTO., MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME P.A.

1201 DUNDALK AVE. BALTIMORE, MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Arteriosclerotic coronary artery disease*

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death*one y.*Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Lymphoma**Dementia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

021022

29d. Date signed (Month, Day, Year)

7-27-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. KOWALCZYK 8114 SANDPIPER CIRCLE BALTO MD 21236

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ANDRE
MOORE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24007

| | | | | | | | | | |
|--|---|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Andre Lavelle Moore | | | | 2. Date of Death Month Day Year JULY 26, 1999 | | 3. Time of Death 4:45 P.M. | | |
| | 4a. Facility Name (If not Institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death None | | |
| Funeral Director | 5. Social Security Number 216-94-0576 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 21 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 13, 1978 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County None | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3662 Chesterfield Ave. | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cabinet Maker | | 16b. Kind of Business/Industry Unknown | | 17. Father's Name (First, Middle, Last) Benjamin Jones | | 18. Mother's Name (First, Middle, Maiden Surname) Eunice Moore | |
| 19a. Informant's Name/Relationship (Type, Print) Eunice Johnson/Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3662 Chesterfield Ave. Baltimore, Maryland 21213 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Park | | 20c. Location - City or Town, State 7-31-99 Woodlawn, Maryland | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility The Derrick C. Jones Funeral Home 4611 Park Heights Ave. Baltimore, Maryland 21215 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7/26/99 | | 28b. Time of Injury 1555 P.M. | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred subject shot | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore City, Md 3232 Chesterfield Ave | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore City, Md 3232 Chesterfield Ave | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dennis J. Chute, MD | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 27, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24008

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET A. NORRIS

2. Date of Death

Month Day Year
July 29 1999

3. Time of Death

10:40 AM

4a. Facility Name (If not institution, give street and number)

Future Care of the Chesapeake

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

219 22 3211

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 27, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

305 College Parkway

10f. Zip Code

21012

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Office Clerk

16b. Kind of Business/Industry

Baltimore City Govt.

17. Father's Name (First, Middle, Last)

Howard M. Ziegler

18. Mother's Name (First, Middle, Maiden Surname)

Cora Miller

19a. Informant's Name/Relationship (Type, Print)

Elmer Norris / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8527 Creek Rd. Pasadena, MD 21122

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

8/2/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Atherosclerotic Cardiovascular Disease*
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death*Several years*Sequentially list conditions,
if any, leading to Immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT SCOTT EDEN, M.D., 600 RIDGELY AVE, ANNAPOLIS, MD 21401

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24009

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Amelia Nowakowski | | | | 2. Date of Death Month Day Year 7-23-99 | | 3. Time of Death 2:30AM | |
| | 4a. Facility Name (If not institution, give street and number) Canton Harbor Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-09-2000 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 4-29-14 | | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County N/A | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 1300 S. Ellwood Avenue | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Maintenance | | | 16b. Kind of Business/Industry Baltimore City | | |
| | 17. Father's Name (First, Middle, Last) Martin Wojtowicz | | | | 18. Mother's Name (First, Middle, Maiden Surname) | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mr. Richard Nowakowski | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12170 Mt. Albert Road Ellicott City, MD 21042 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus | | Date 7-27-99 | | 20c. Location - City or Town, State Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee <i>Charles Kaczorowski</i> | | | 22. Name and Address of Facility Kaczorowski Funeral Home 1201 Dundalk Avenue Balto., MD 21222 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): b. ASCD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Yes | | | | | | | |
| | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Arterial Hypertension, Peptic Ulcer Disease | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Simon V. Scalia</i> | | 29c. License number D24276 | | 29d. Date signed (Month, Day, Year) 7-26-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIMON V. SCALIA CANTON HARBOR NURSING HOME | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature <i>G. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24010

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Virginia Phillips

2. Date of Death

Month Day Year
July 30, 1999

3. Time of Death

2:42 AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-52-4321

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
MAR 10, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2805 Shirey Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Programmer

16b. Kind of Business/Industry

Law Firm

17. Father's Name (First, Middle, Last)

Joseph Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Helen Hovermale

19a. Informant's Name/Relationship (Type, Print)

Robert S. Phillips/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10053 Hughes Street Conifer, CO 80433

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 7/30/99 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. rectal cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

July 30, 1999

30. Name and address of person who completed cause of death (Part 23a) (Type, Print)

W.A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

B. Sparks

State
Registrar

BARBARA PHILLIPS July 30 1999
Baltimore, Maryland 21215-0020 0242
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

7-14-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24011

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | |
|--|--|--|---|--------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) <i>Elva E. Palmer</i> | | | 2. Date of Death Month <i>7</i> Day <i>27</i> Year <i>1999</i> | | 3. Time of Death <i>11:50am</i> |
| 4a. Facility Name (If not institution, give street and number) <i>Future Care Old Court</i> | | | 4b. City, Town, or Location of Death <i>Randallstown</i> | | 4c. County of Death <i>Baltimore</i> |
| 5. Social Security Number <i>216-80-3303</i> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>85</i> Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>May 22, 1914</i> |
| Usual Residence of Decedent | | | 9. Birthplace (State or Foreign Country) <i>Maryland</i> | | |

Funeral
Director

To Be Completed by Funeral Director

| | | | | |
|---|---------------------------------|---|--|--|
| 10a. State <i>Maryland</i> | 10b. County <i>Baltimore</i> | 10c. City, Town or Location <i>Randallstown</i> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number <i>3109 Offutt Road</i> | | 10f. Zip Code <i>21133</i> | | 10g. Citizen of What Country? <i>United States</i> |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th Grade</i> College (1-4 or 5+) <i>-0-</i> | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i> | | 16b. Kind of Business/Industry <i>Own Home</i> | | |
| 17. Father's Name (First, Middle, Last) <i>Franklin Frederick Kirk</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Louise List</i> | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Margaret Davis - Sister</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4406 Deer Park Road; Owings Mills, Maryland 21117</i> | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lorraine Park Cemetery</i> | | 20c. Location - City or Town, State <i>7/30/99 Woodlawn, Maryland</i> |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility <i>Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133</i> | | |

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

| | | | | |
|---|--|---|--------------------------|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Coronary artery disease</i> Due to (or as a consequence of): <i>Arteriosclerosis</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>Congestive Heart Failure</i> | | | | Approximate Interval Between Onset and Death <i>10 years</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number <i>D0020964</i> | | 29d. Date signed (Month, Day, Year) <i>07/29/99</i> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133</i> | | | | |
| 31. Date filed (Month, Day, Year) <i>JUL 30 1999</i> | | 32. Registrar's Signature <i>[Signature]</i> | | |

State
Registrar

Baltimore, Maryland 21215-0020

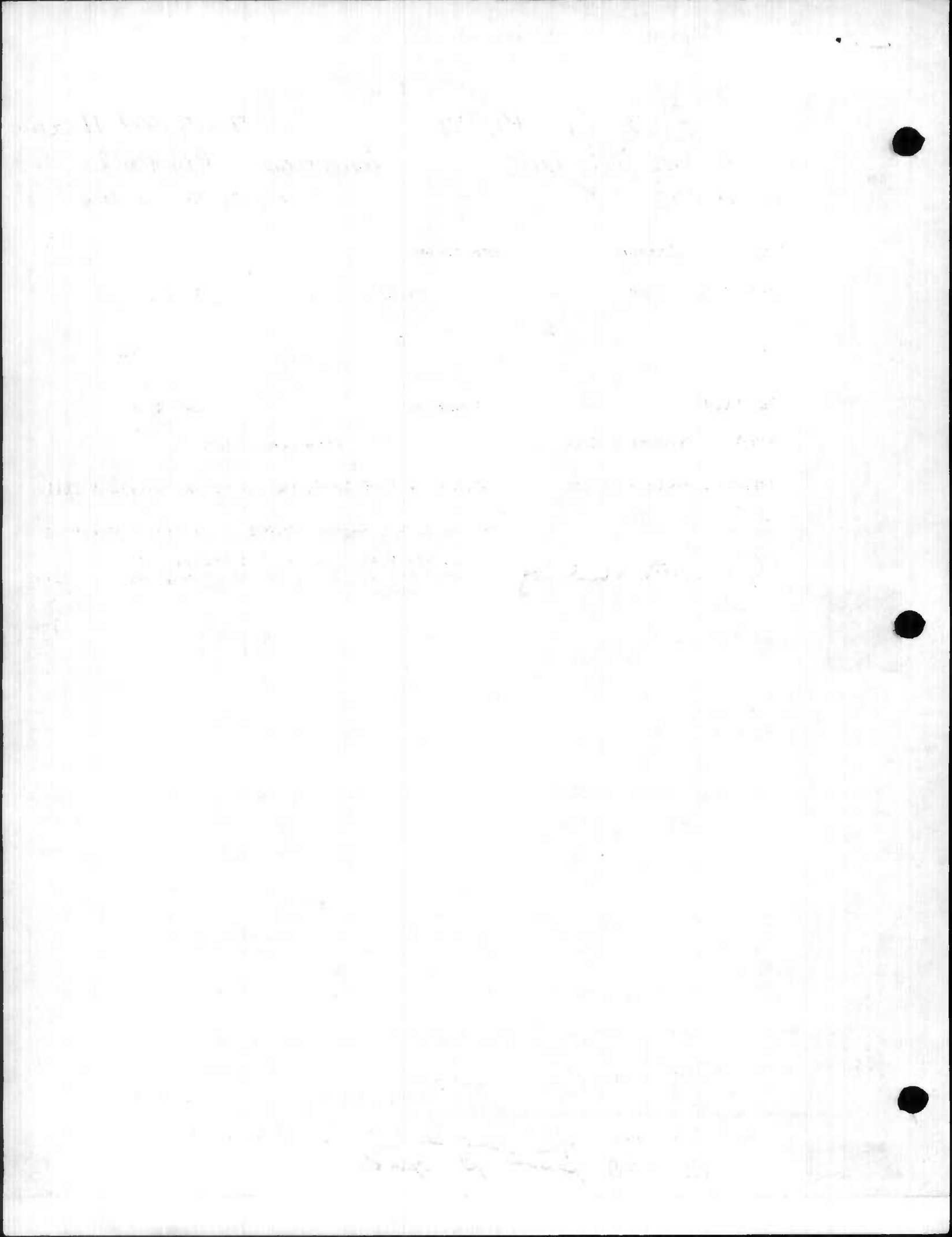
Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

MLSTATE

7-10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24012

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 8-11-99

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Frank Paul JR. | | | | 2. Date of Death Month Day Year July 22, 1999 | | 3. Time of Death 03:30 PM. | |
| | 4a. Facility Name (If not institution, give street and number) 623 North Duncan Street | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 217-50-5004 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 49 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 7-28-50 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md | 10b. County | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 623 N. Duncan St. | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry UNK | | | |
| | 17. Father's Name (First, Middle, Last) Frank Paul SR. | | | | 16. Mother's Name (First, Middle, Maiden Surname) Mary High Smith | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Theresa Paul-driver | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1414 N. Collington Ave. | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State 7-309 Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Jeff Miller | | 22. Name and Address of Facility Jeff Miller Funeral Home 1634 N. Broadway | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SUBDURAL HEMATOMA AND CIRRHOSIS OF THE LIVER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7-22-99 | | 28b. Time of Injury FOUND: 3:15 PM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SUBJECT FELL. |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) UNKNOWN | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Harriet Dorell | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) July 23, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melvin D. KOROLMY 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24013

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CARL WERNER PRIOR JR. | | | | 2. Date of Death Month Day Year July 25 1999 | | 3. Time of Death 8:32P | | | |
| | 4e. Facility Name (If not institution, give street and number) Stella Maris Hospice | | | | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore | | | |
| Funeral Director | 5. Social Security Number 218-05-9288 | | 6. Sex XX M 20 F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) March 29, 1918 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent 10a. State Maryland | | | | 10b. County Baltimore | | 10c. City, Town or Location Lutherville | | 10d. Inside City Limits 10 Yes XX No | |
| To Be Completed by Funeral Director | 10e. Street and Number 215 Belmont Forest Court | | | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 10 Never Married XX Married 30 Widowed 40 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 20 No WWII If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes XX No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Superintendent | | 16b. Kind of Business/Industry Construction | | | |
| | 17. Father's Name (First, Middle, Last) Carl Werner Prior Sr | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marga Christensen | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Harriet D. Prior Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Belmont Forest Ct Lutherville, Maryland 21093 | | | | | |
| | 20a. Method of Disposition 10 Burial XX Cremation 30 Removal from State 40 Donation 50 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery | | Date 7/28/99 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Annis Hester Kuaks | | | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. COLON CANCER Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 4X Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed? 10 Yes 2X No | | 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 10 Yes 2X No | | 26. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 6X Other (Specify) HOSPICE | | | | | | | |
| | 27. Manner of Death 1X Natural 50 Pending investigation 20 Accident 60 Could not be determined 30 Suicide 40 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 10 Yes 20 No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Tariq Mahmood | | | | | | | |
| | 29c. License number D43725 | | 29d. Date signed (Month, Day, Year) 7/27/99 | | | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEYR D. TIMONIUM, MD 21093 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature Benjamin G. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24014

| | | | | | | | | | | |
|--|---|---|---|--|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALEEN, RHODES | | | | 2. Date of Death Month July Day Twenty-Sixth Year 1999 | | | | 3. Time of Death 3:43AM | |
| | 4a. Facility Name (If not institution, give street and number) MERCY MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE, MD | | | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 213-22-1980 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) Seventy-Four rs. | | 8. Date of Birth (Month, Day, Year) JULY TWENTY, 1925 | | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 13615 GILBRIDE LANE | | | | 10f. Zip Code 21029 | | | | 10g. Citizen of What Country? US | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th GRADE College (1-4or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) House Wife | | | | 16b. Kind of Business/Industry Home | | |
| 17. Father's Name (First, Middle, Last) Thomas Gaither | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Minerva Williams | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Celeste Hunter - daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1823 Jacobs Dr, Greenbelt MD 20770 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem Park | | | 20c. Location - City or Town, State Arbutus, MD | | | |
| 21. Signature of Funeral Service Licensee James A. Thompson | | | | 22. Name and Address of Facility MARCH F/H 4300 WABASH AVE, BALTO MD 21215 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE MYELOMA Due to (or as a consequence of): b. NEUTROPENIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Approximate Interval Between Onset and Death one year one month | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Jennifer Morrow, MD | | | | 29c. License number AU4176435AM1982 | | | | 29d. Date signed (Month, Day, Year) July Twenty-Six, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. MORROW 22 S. Greene St., Baltimore MD 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | | | 32. Registrar's Signature Anna B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2012, 6/23/12

5071. 22. 21. 2

00000000000000000000000000000000

18612 2118410 2118411

15

4.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #11, 17 PER F.H. G773 WR.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS #26 & #27 PER MD G773 7/30/99 AH

Certificate of Death

Reg. No.

99 24015

| | | | | | | | | | | |
|--|---|------------------------------|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Irene | | | 2. Date of Death Month June Day 22 Year 1999 | | | 3. Time of Death 1844 pm | | | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | | 4c. County of Death | | | |
| Funeral Director | 5. Social Security Number 353-26-3986 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 7, 1931 | | 9. Birthplace (State or Foreign Country) Illinois | |
| | Usual Residence of Decedent | | | 10c. City, Town or Location | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10a. State Maryland | | 10b. County Howard | | 10e. Street and Number 8548 Reservoir Road | | | 10f. Zip Code 20759 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own home | | | | |
| 17. Father's Name (First, Middle, Last) MICHAEL POTOCKI William F. Potocki | | | 18. Mother's Name (First, Middle, Maiden Surname) Stella Kurg | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jacqueline Randall/daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8205 S.E. Harney #2, Portland, OR 97266 | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC. | | | 20c. Location - City or Town, State 7/21/99 BALTIMORE, MD. | | | | |
| 21. Signature of Funeral Service Licensee Edward A. Gregorich Ronald S. Wade, Director | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | 22. Name and Address of Facility CREMATION SOCIETY OF MD, INC. 21228 555 FREDERICK ROAD, BALTIMORE MD. | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Immediate Cause (Final disease or condition resulting in death) a. mitral valve disease Due to (or as a consequence of): b. rheumatic heart disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | Approximate Interval Between Onset and Death 3 years 63 years | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier Elaine Lee MD | | | 29c. License number Res 000 | | | 29d. Date signed (Month, Day, Year) June 22 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 North Wolfe Street Baltimore Maryland. 21287 | | | 31. Date filed (Month, Day, Year) JUL 30 1999 | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24016

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Lowell Lawrence Ripple

2. Date of Death

Month
07Day
27Year
1999

3. Time of Death

/300

4a. Facility Name (If not institution, give street and number)

Deaton University of Maryland Medicine Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

5. Social Security Number

215-36-4770

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
OCT 2, 1940

9. Birthplace (State or Foreign Country)

District of Columbia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Jessup

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8315 Ari Court, Apt. 2D

10f. Zip Code

20794

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Handyman

16b. Kind of Business/Industry

Miscellaneous Jobs

17. Father's Name (First, Middle, Last)

Franklin Oliver Ripple

18. Mother's Name (First, Middle, Maiden Surname)

Millicent Lucele Weitkamp

19a. Informant's Name/Relationship (Type, Print)

Donna L. Koons/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Ironmaster Ct. Thurmont, MD 21788

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 7/28/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorichuk

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic adenocarcinoma of Liver

6 mhs

Due to (or as a consequence of):

b. Chronic obstructive lung disease

5 yrs

Due to (or as a consequence of):

c. COPD/pulmonary

11

Due to (or as a consequence of):

d. Respiratory failure vent dependent

4 mhs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28i. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Edward A. Gregorichuk

29c. License number

D304194

29d. Date signed (Month, Day, Year)

July 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward A. Gregorichuk Deaton Medical Center 611 South Charles St Baltimore MD 21230

State
Registrar

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

James B. Sparks

Lowell Lawrence Ripple
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2025 1000 + 5 10

11/15/2025

Reg. No.

DMMH 16 Rev 6/95

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is crucial for ensuring the integrity of the financial system and for providing a clear audit trail.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps that must be followed, from the initial entry of the transaction into the system to the final review and approval.

3. The third part of the document discusses the role of the various departments involved in the process. It explains how each department contributes to the overall goal of maintaining accurate records and how they must work together to ensure that the process is completed efficiently and effectively.

4. The fourth part of the document discusses the importance of training and education for all personnel involved in the process. It emphasizes that all personnel must be properly trained and educated in order to ensure that the process is completed accurately and efficiently.

5. The fifth part of the document discusses the importance of regular audits and reviews. It explains that these are necessary to ensure that the process is being followed correctly and that any errors or discrepancies are identified and corrected in a timely manner.

6. The sixth part of the document discusses the importance of maintaining the confidentiality of the information. It emphasizes that all information must be kept secure and that access must be restricted to only those personnel who are authorized to view it.

7. The seventh part of the document discusses the importance of maintaining the accuracy of the information. It emphasizes that all information must be entered correctly and that any errors or discrepancies must be identified and corrected in a timely manner.

8. The eighth part of the document discusses the importance of maintaining the integrity of the financial system. It emphasizes that this is the ultimate goal of the entire process and that all other steps must be taken to ensure that this goal is achieved.

9. The ninth part of the document discusses the importance of maintaining the transparency of the process. It emphasizes that all transactions must be recorded and that the records must be available for review and audit.

10. The tenth part of the document discusses the importance of maintaining the accountability of the personnel involved. It emphasizes that all personnel must be held responsible for their actions and that any failures must be identified and corrected in a timely manner.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24018

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Eva R. Reamy | | | | 2. Date of Death Month Day Year July 26 99 | | | | 3. Time of Death 7:25 pm | |
| | 4a. Facility Name (If not institution, give street and number) Charlestown Care Center | | | | 4b. City, Town, or Location of Death Catonsville | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 218-09-9977 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 97 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 05/27/1902 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 709 Maiden Choice Lane | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Civil Service | | | 16b. Kind of Business/Industry Government | | |
| | 17. Father's Name (First, Middle, Last) James Patience | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rosie Schifel | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Dorothy Steyert/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3728 Mac Alpine Road/Ellicott City, Md 21042 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National | | | Data 7/29 | | 20c. Location - City or Town, State Baltimore, Md | |
| | 21. Signature of Funeral Service Licensee Mae K. Marshall | | | | 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage Congestive Heart failure Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Andres Salazar MD | | | | 29c. License number D 51051 | | | 29d. Date signed (Month, Day, Year) July 27, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Andres Salazar 711 Maiden choice lane, Catonsville, MD, 21228 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | |

July 20 1952

William L. Garrison

Dear Sir:

I have been thinking of you a great deal lately and wondering how you are getting on. I hope you are well and happy. I have been very busy lately but I have managed to find some time to write to you. I have been thinking of you a great deal lately and wondering how you are getting on. I hope you are well and happy. I have been very busy lately but I have managed to find some time to write to you.

Yours truly,

Wm. L. Garrison
July 20 1952
New York City

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24019

AMENDED ITEM #22 PER FH G773 7/30/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN A. REINHARDT

2. Date of Death

Month

Day

Year

July

28

1999

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

489-01-1365

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 29, 1908

9. Birthplace (State or Foreign Country)

MO

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Dayton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4940 Ten Oaks Road

10f. Zip Code

21036

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph D. Smythe

18. Mother's Name (First, Middle, Maiden Surname)

Anna Douchek

19a. Informant's Name/Relationship (Type, Print)

Leon J. Murphey (Son-in-Law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13483 Open Space Court, Highland, MD 20777

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Calvary Cemetery

Date

8/2/99

20c. Location - City or Town, State

St. Louis, Missouri

21. Signature of Funeral Service Licensee

Robert S. Bueh

22. Name and Address of Facility

KNOLLS

Witzke Funeral Homes, Inc.

5555 Twin Oaks Road, Columbia, Maryland 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jonathan Fish MD

29c. License number

D 51960

29d. Date signed (Month, Day, Year)

July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN FISH MD 3460 ELLICOTT CTR DR #103 ELLICOTT CITY MD 21043

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24020

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Raymond E. Steffey, Sr.

2. Date of Death

Month Day Year
July 26 1999

3. Time of Death

23:33

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

215-16-0447

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 12, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6203 Hilltop Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Phillips Brother
Warehouse, Inc.

17. Father's Name (First, Middle, Last)

Raymond R. Steffey

18. Mother's Name (First, Middle, Maiden Surname)

Vashti Collins

19a. Informant's Name/Relationship (Type, Print)

Vivian E. Steffey Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6203 Hilltop Avenue Baltimore, Maryland 21206

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland Veteran Cemetery 7/30/99 Garrison Forest, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 2121123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

13 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Cardiogenic Shock

Due to (or as a consequence of):

3 days

c. Arrhythmia

Due to (or as a consequence of):

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Atherosclerosis

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

July 26 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Lewis Union Memorial Hospital Baltimore, MD

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24021

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Rebecca Sykes</u> | | | | 2. Date of Death Month <u>07</u> Day <u>28</u> Year <u>99</u> | | 3. Time of Death <u>0109</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>UMMS</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>Baltimore City</u> | |
| Funeral Director | 5. Social Security Number <u>218-36-8692</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>58</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>March 23, 1941</u> | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | 10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10a. State <u>Maryland</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>Baltimore</u> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number <u>16 N. Mount St.</u> | | 10f. Zip Code <u>21223</u> | | 10g. Citizen of What Country? <u>USA</u> | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. <u>Afro-American</u> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>0</u> College (1-4 or 5+) <u>0</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u> | | 16b. Kind of Business/Industry <u>Own Home</u> | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <u>Charles Noakes</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Gwendolyn Burrell</u> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Mr Eugene Sykes (Husband)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>16 N. Mount St. Balto. Md. 21223</u> | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Greenmount Crematory</u> | | 20c. Location - City or Town, State <u>Balto. Md.</u> | | 20d. Date <u>8/3/99</u> | |
| | 21. Signature of Funeral Service Licensee <u>Joseph L. Russ</u> | | 22. Name and Address of Facility <u>Joseph L. Russ Funeral Home</u> <u>2222 W. North Ave. Balto. Md. 21216</u> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Exsanguination</u> Due to (or as a consequence of) <u>hemorrhage</u> <u>Bleeding open wound bypass surgery on abdomen</u> Due to (or as a consequence of): <u>peripheral vascular disease</u> Due to (or as a consequence of): <u>Hypertension</u> | | Approximate Interval Between Onset and Death | |
| To Be Completed by Physician/Medical Examiner | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>End stage renal disease with organs dialysis</u> | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier <u>[Signature]</u> | | | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number <u>045857</u> | | 29d. Date signed (Month, Day, Year) <u>07/28/99</u> | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dick Kuo</u> <u>UNIVERSITY HOSPITAL</u> <u>22 S. GREENE ST.</u> | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <u>JUL 30 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

JUL 3 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24022

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MERRITT T. SMITH, JR.

2. Date of Death

Month Day Year
July 28, 1999

3. Time of Death

8:00 p.m.

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

163-10-3086

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 22, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baldwin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13718 Baldwin Mill Road

10f. Zip Code

21013

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

C.E.O.

16b. Kind of Business/Industry

Armored Car Service

17. Father's Name (First, Middle, Last)

Merritt T. Smith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Harriet (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Linda Smith Pocius (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13718 Baldwin Mill Road, Baldwin, MD. 21013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highview Memorial Gardens 7/31/99 Fallston, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

acute Renal Failure

Approximate Interval Between Onset and Death

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Hypotension

4 days

Due to (or as a consequence of):

Myocardial infarction

4 days

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senentia

Chronic Obstructive Lung Dx

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mark Lamas MD

29c. License number

D34521

29d. Date signed (Month, Day, Year)

7-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Lamas MD, 9 Schell Rd. Hunt Valley MD 21030

State
Registrar

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24023

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEONARD SESSIONS | | 2. Date of Death Month Day Year July 27, 1999 | | 3. Time of Death 13:54 |
| | 4a. Facility Name (If not Institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 212-74-7559 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 44 Yrs. | 8. Date of Birth (Month, Day, Year) 11-24-54 | 9. Birthplace (State or Foreign Country) MD. |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number 719 E. 20th ST. | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (14 or 5+) -0- | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | 16b. Kind of Business/Industry CONSTRUCTION | | |
| | 17. Father's Name (First, Middle, Last) LENORD SESSIONS SR. | | 18. Mother's Name (First, Middle, Maiden Surname) IDA THOMPSON | | |
| | 19a. Informant's Name/Relationship (Type, Print) IDA THOMPSON (MOTHER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 E. 20th ST. BALTIMORE, MARYLAND 21218 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Location - City or Town, State BALTIMORE, MARYLAND |
| | 21. Signature of Funeral Service Licensee Dorothy Heater | | 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) a. Septic shock Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 2 weeks |
| | b. Due to (or as a consequence of): | | | | |
| | c. Due to (or as a consequence of): | | | | |
| | d. Due to (or as a consequence of): | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hepatic failure secondary to cirrhosis, HIV | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) July 27, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICOL ROTHMAN, JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature [Signature] | | |

ORIGINAL

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24024

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Roland Linfield Shackelford Sr.

2. Date of Death

Month
JULY

Day

27th

Year

1999

3. Time of Death

2:30 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore City

5. Social Security Number

215671708

6. Sex

1st M 2nd F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 27, 1912

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1st Yes 2nd No

10e. Street and Number

9125 Avondale Road

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1st Never Married 2nd Married3rd Widowed 4th Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1st Yes 2nd No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1st Yes 2nd No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Tool & Dye Maker

16b. Kind of Business/Industry

Aberdeen Proving Grounds

17. Father's Name (First, Middle, Last)

David Eugene Shackelford

18. Mother's Name (First, Middle, Maiden Surname)

Sophie Mabel Fritzsche

19a. Informant's Name/Relationship (Type, Print)

Etta L. Shackelford (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9125 Avondale Road Baltimore, Maryland 21234

20a. Method of Disposition

1st Burial 2nd Cremation 3rd Removal from State4th Donation 5th Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Cemetery July 30, 1999

Data

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jonathan Joseph Chernock

22. Name and Address of Facility

Lassahn Funeral Home Inc

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE SEPSIS

Due to (or as a consequence of):

b. PELVIC ABSCESS

Due to (or as a consequence of):

c. PERFORATED SIGMOID DIVERTICULUM

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

COR PULMONALE

23b. Did tobacco use contribute to the cause of death?

1st Yes 2nd No 3rd Probably 4th Unknown

24a. Was an autopsy performed?

1st Yes 2nd No

24b. Were autopsy findings available prior to completion of cause of death?

1st Yes 2nd No

25. Was case referred to medical examiner?

1st Yes 2nd No

Hospital:

1st Inpatient 2nd ER/Outpatient 3rd DOA

26. Place of Death (Check only one)

4th Nursing Home 5th Residence 6th Other (Specify)

27. Manner of Death

1st Natural2nd Accident3rd Suicide4th Homicide5th Pending investigation6th Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1st Yes 2nd No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2nd Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

ANU GABA MD.

29c. License number

P 12560

29d. Date signed (Month, Day, Year)

JULY 27th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANU GABA, RESIDENT, GOOD SAMARITAN HOSPITAL, BALTIMORE 21239

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

*Bonnie B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24025

| | | | | | | | | | |
|--|---|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CARMEN A. STROLLO | | | | 2. Date of Death Month July Day 27 Year 1999 | | 3. Time of Death 1600 | | |
| | 4a. Facility Name (If not institution, give street and number) Church Home Hospital Balto | | | | 4b. City, Town, or Location of Death BALTO | | 4c. County of Death NIA | | |
| Funeral Director | 5. Social Security Number 144-22-6123 | | 6. Sex 1 Male 2 Female | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov 27, 1928 | | |
| | 9. Birthplace (State or Foreign Country) N.J. | | 10a. State MD | | 10b. County NIA | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 1008 Stiles St | | 10f. Zip Code 21202 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1952 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NIA | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Line Repairman | | 16b. Kind of Business/Industry Dept of Transportation | | 17. Father's Name (First, Middle, Last) Joseph Strollo | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Muholic | | 19a. Informant's Name/Relationship (Type, Print) Carmen Strollo JR. Po Box 765 Ocean View Del 19970-0765 | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | 20c. Location - City or Town, State Baltimore Md. | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility DELLA NOCE & SONS FUNERAL HOME 322 S. HIGH ST. BALTO 21202 MD. | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UROSEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Severe Dehydration Malnutrition | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | 24a. Was an autopsy performed? 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | Approximate Interval Between Onset and Death days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Dehydration Malnutrition | | 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> Ind. Specialist | | 29c. License number D40356 | | 29d. Date signed (Month, Day, Year) JULY 27, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WENGUSAT-NAVARRO, MD. 100 N. Broadway, Baltimore, Maryland 21231 | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature <i>[Signature]</i> B. Sparks | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once. | |

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24026

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Richard Hewitt Shickel | | | | 2. Date of Death Month July Day 27 Year 1999 | | | | 3. Time of Death 2025 | | | |
| 4a. Facility Name (If not institution, give street and number) 1836-C Treeview Ct. | | | | 4b. City, Town, or Location of Death Crofton | | | | 4c. County of Death AA | | | |
| 5. Social Security Number 134-12-9530 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 25, 1914 | | 9. Birthplace (State or Foreign Country) Illinois | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Crofton | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 1836 Treeview Court, Apt. C | | | | 10f. Zip Code 21114 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Admissions Counselor | | | | 16b. Kind of Business/Industry Business School | | | |
| 17. Father's Name (First, Middle, Last) James B. Shickel | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Fannie M. Hewitt | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) David O. Shickel (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1725 Mayfair Place, Crofton, MD 21114 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oakwood Cemetery | | | | Date 07/31 | | 20c. Location - City or Town, State Syracuse, NY | |
| 21. Signature of Funeral Service Licensee Batrick J. Smith | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure minutes Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier William P. Jones, MD Deputy | | | | 29c. License number D06054 | | | | 29d. Date signed (Month, Day, Year) 7/27/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 America 21035 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | | | 32. Registrar's Signature James B. Sparks | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

10710

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24027

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD LEVERE SAUERWALD

2. Date of Death

Month Day Year
July 27, 1999

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

3110 Greenhill Road

4b. City, Town, or Location of Death

Edgemere

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

176-01-5408

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 21, 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3110 Greenhill Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10 Years

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Irwin Sauerwald

18. Mother's Name (First, Middle, Maiden Surname)

Ida Mae Geesey

19a. Informant's Name/Relationship (Type, Print)

Mr. Paul M. Sauerwald/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

442 Westfield Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 7/30/1999

Date

20c. Location - City or Town, State

Rossville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastric Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Valvular Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D39660

29d. Date signed (Month, Day, Year)

July 28, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Robert C. Dart, Jr. MD 7566 North Point Rd. Baltimore MD 21219

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

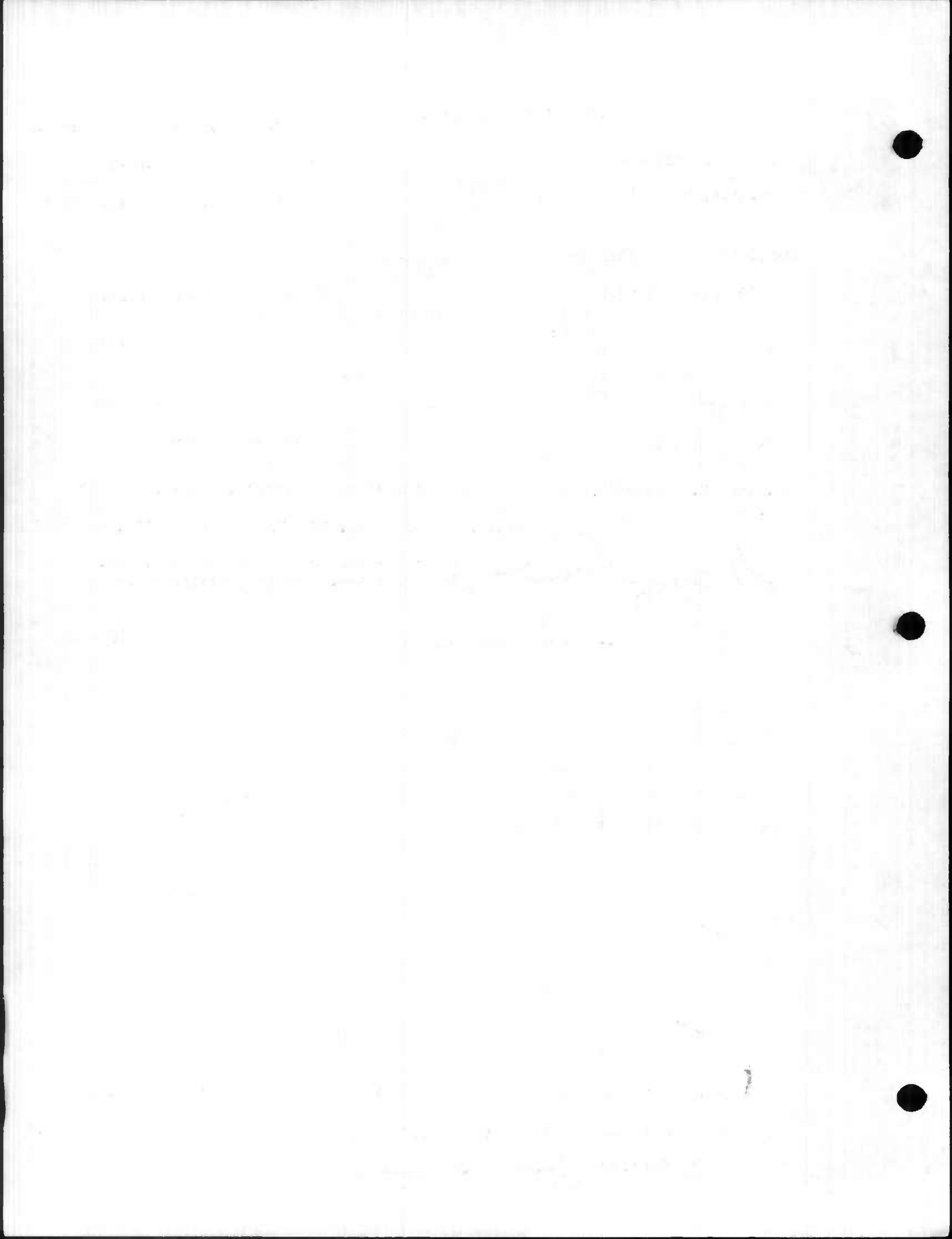
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#24a per verbal Md 6773 7/30/99 EW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSEMARY TIFFANY

2. Date of Death

Month 7 Day 13 Year 1999

3. Time of Death

11:17AM

4a. Facility Name (If not institution, give street and number)

Nanorcare Towson

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

Funeral
Director

5. Social Security Number

106-32-9623

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 7/13/1999

9. Birthplace (State or Foreign Country)

Cleveland, OH

Usual Residence of Decedent

10e. State

MD

10b. County

Baltimore

10c. City, Town or Location

White Hall, MD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Zella Court

10f. Zip Code

21161

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4 yrs

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

school teacher

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

Carl Douglas Walkach

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Patee

19a. Informant's Name/Relationship (Type, Print)

Robert Tiffany

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Zella Ct. White Hall, MD 21161

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD State Anatomy Bld.

Date

7/13/99

20c. Location - City or Town, State

TOWSON, MD

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

N/A

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Eustice

29c. License number

D34952

29d. Date signed (Month, Day, Year)

7/13/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. EUSTICE MD, 7600 OSLER DRIVE, TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

2007 10 12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes M. Tehan

2. Date of Death

Month
July

Day
28

Year
1999

3. Time of Death

6:55 A.M.

4a. Facility Name (If not institution, give street and number)

5845 Richardson Mews

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

059 01 7768

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 27, 1912

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5845 Richardson Mews

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

James Bannon

18. Mother's Name (First, Middle, Maiden Surname)

Anna Farrell

19a. Informant's Name/Relationship (Type, Print)

Ann Tehan / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5845 Richardson Mews Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

Date

7-31-99

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Anna M. Brzezinski

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Lymphocytic Leukemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

Alan Reisinger III

29c. License number

D30631

29d. Date signed (Month, Day, Year)

7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Reisinger III, M.D. 5411 Old Frederick Rd Belts MD 21228

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24030

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Elizabeth Tunstall

2. Date of Death

Month
7Day
23Year
99

3. Time of Death

8:38 PM

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore, Md.

4c. County of Death

N/A

5. Social Security Number

213-269783

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month, Day, Year

9. Birthplace (State or Foreign Country)

May 13, 1931 Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

202 S Catherine St.

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietician

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Andrew Tunstall

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Phillips

19a. Informant's Name/Relationship (Type, Print)

Beverly Tunstall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 S. Catherine St. Balto, MD. 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cemetery

Date

7-29-99

20c. Location - City or Town, State

Dwight Mills, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Mary P. March Funeral Home P.A.
470 Fred Hilton Pass Baltimore, MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Bacterial Endocarditis

Due to (or as a consequence of):

b. Osteomyelitis

Due to (or as a consequence of):

c. Septicemia

Due to (or as a consequence of):

d. Chronic renal failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician

10. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D18327

29d. Date signed (Month, Day, Year)

7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Moges Gebremariam 4660 W. Lakes Ave Balto Md 21228

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24031

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward Carlton Valentine | | | | 2. Date of Death Month Day Year JULY 26, 1999 | | 3. Time of Death 0250 AM | |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-88-7382 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 33 Yrs. | | 8. Date of Birth Month Day Year May 2, 1966 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 821 Bradford St. | | 10f. Zip Code 21205 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: African American | | | | 14. Race - American Indian, Black, White, etc. Specify: African American | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | | 16b. Kind of Business/Industry Private Co. | | 17. Father's Name (First, Middle, Last) Selester Valentine | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Martha Davis | | | | 19a. Informant's Name/Relationship (Type, Print) (wife) Mrs. Tina Valentine | | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 656 Smithson St. Balto, Md. 21217 | | | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | | | 20c. Location - City or Town, State Balto, Md. | | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gunshot Wound to Back | | | | Approximate Interval Between Onset and Death | | | |
| | 23b. Due to (or as a consequence of): a. Gunshot Wound to Back b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) 7/26 | | | |
| | 28b. Time of Injury 0200 M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred Subject shot | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street; Found 821 N. Bradford St. Baltimore, Md | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| State Registrar | 29b. Signature and title of certifier Joseph L. Russ, M.D. | | | | 29c. License number O.C.M.E | | | |
| | 29d. Date signed (Month, Day, Year) JULY 27, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 30 1999 | | | | 32. Registrar's Signature B. Sparks | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

A42

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24032

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|--|--|---|--------------------------|--|--|---|--|--|---|---|-------------------------------|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carolyn C. Wieczorek | | | | 2. Date of Death Month Day Year July 28, 1999 | | 3. Time of Death 6:32 AM | | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number) Colonial Manor Nursing Home | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | | | | | | | | |
| Funeral Director | 5. Social Security Number 214-38-3360 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT 22, 1913 | | 9. Birthplace (State or Foreign Country) UNK. | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 6348 Frederick Road | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? USA | | | | | | | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | 16b. Kind of Business/Industry Education | | | | | | | |
| | 17. Father's Name (First, Middle, Last) George A. Wieczorek | | | | 18. Mother's Name (First, Middle, Maiden Surname) Corinne Giacomini | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Corrine Wieczorek/Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 E. Joppa Road, Apt. 103 Towson, MD 21286 | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery | | Date 8/2/99 | | 20c. Location - City or Town, State Woodlawn, MD | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | | | 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 | | | | | | | | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. A.S.C.A.D. & MI. Due to (or as a consequence of): b. H.C.V.D. = CHF. Due to (or as a consequence of): c. Renal failure Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier [Signature] | | 29c. License number D13366 | | 29d. Date signed (Month, Day, Year) 7/28/99. | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Adnan M. Samiez 503 N. Rolling Road Bal. Md. 21228 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24033

| | | | | | | | | |
|--|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harry Wolf | | | | 2. Date of Death Month Day Year July 17 1999 | | 3. Time of Death 11:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) Manor Care Springs house | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 540-07-8253 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) February 26 1912 | |
| | 9. Birthplace (State or Foreign Country) Oregon | | 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Columbia | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 7218 Dockside Lane | | 10f. Zip Code 21045 | | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physicist | | 16b. Kind of Business/Industry U.S. Government | | |
| 17. Father's Name (First, Middle, Last) Jacob Wolf | | | | 18. Mother's Name (First, Middle, Maiden Surname) Johanna Augusta Renschke | | | | |
| 19a. Informant's Name/Relationship (Type, Print) R. Peter Wolf/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7001 Barkwater Ct., Bethesda, MD 20817-4402 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | 20d. Date | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Glischizstoma Due to (or as a consequence of): a. b. c. d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier STEVEN H. EVERSLEY MD | | 29c. License number DS 0776 | | 29d. Date signed (Month, Day, Year) 7/26/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN H. EVERSLEY MD 4801 Dorsen Hill Drive Suite 201B Ellicott City MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

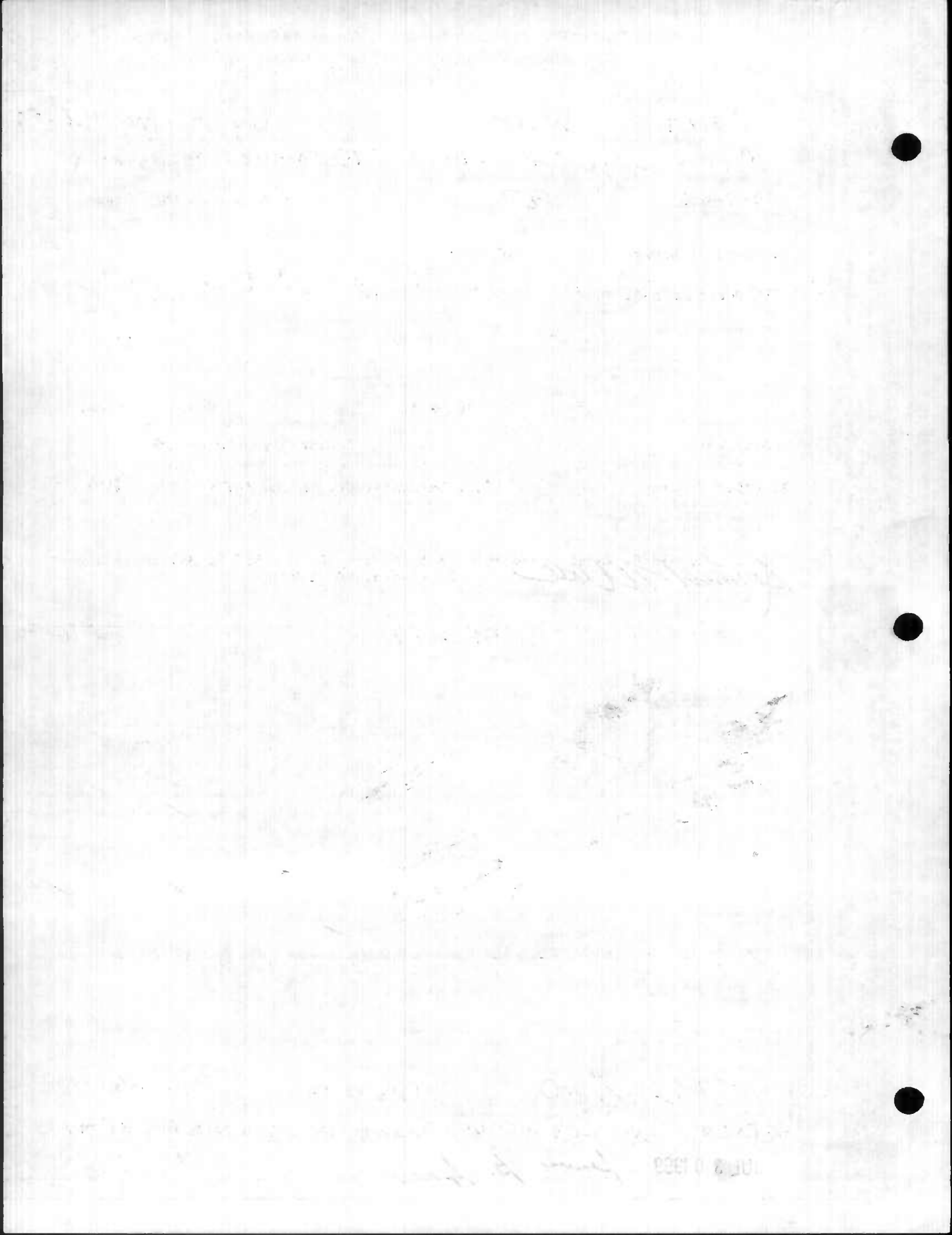
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



99-4274-005

ADELE
WATTS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

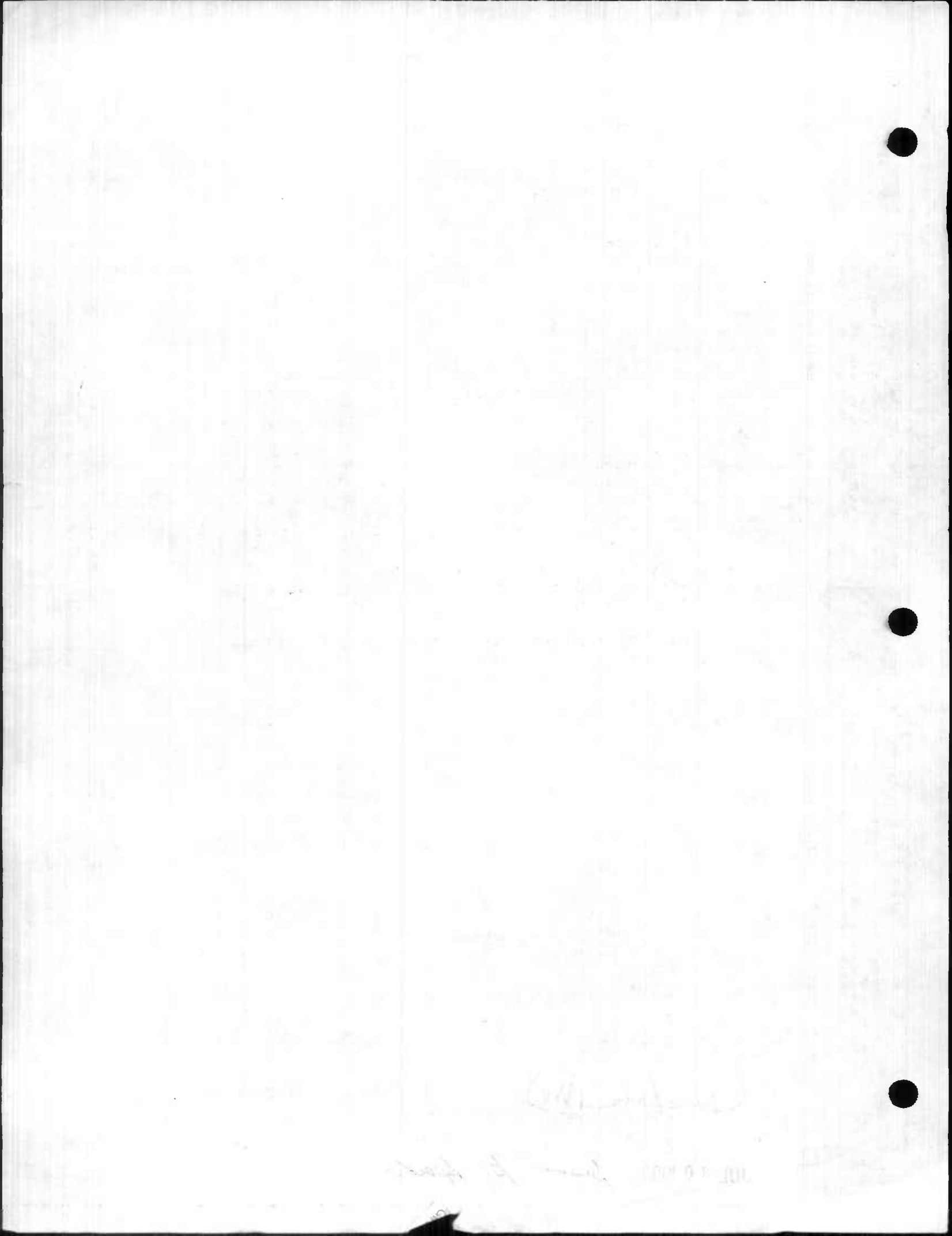
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24.031

| | | | | | | | |
|-----------------------------|--|---|--|---|--|---|--|
| Physician /Medical Examiner | | 1. Decedent's Name (First, Middle, Last) Adele LaFever Watts | | 2. Date of Death Month Day Year JULY 20, 1999 | | 3. Time of Death 7:18P.M. | |
| Funeral Director | | 4a. Facility Name (If not institution, give street and number) 5713 EDMONDSON AVE | | 4b. City, Town, or Location of Death CATONSVILLE | | 4c. County of Death BALTIMORE | |
| | | 5. Social Security Number 216-32-7428 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 | |
| | | 8. Under 1 Year Months Days | | 9. Under 24 Hrs. Hours Min. | | 6. Date of Birth (Month, Day, Year) Sept 3, 1903 | |
| | | Usual Residence of Decedent | | 10a. State MD | | 10b. County Baltimore | |
| | | 10c. City, Town or Location Catonsville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | 10e. Street and Number 5713 Edmondson Avenue | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? U.S.A. | |
| | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Grocery Proprietor | |
| | | 16b. Kind of Business/Industry Funk's Market | | 17. Father's Name (First, Middle, Last) William Funk | | 18. Mother's Name (First, Middle, Maiden Surname) Isabelle Hooper | |
| | | 19a. Informant's Name/Relationship (Type, Print) Edgar Thomas Wheeler, Sr. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 461 Mason Lane, Arnold, MD 21012 | | | |
| | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery | | Date 7/30/99 | |
| | | 20c. Location - City or Town, State Baltimore, Maryland | | 21. Signature of Funeral Service Representative | | 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 | |
| | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | 24a. Was an autopsy performed? inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier J. Laron Locke M.D. | | 29c. License number O.C.M.E. | |
| | | 29d. Date signed (Month, Day, Year) JULY 21, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D., 111 Penn Street, Baltimore, Maryland 21201 | | | |
| | | 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature B. Sparks | | | |
| | | State Registrar | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24035

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|--|--|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HARRY LIONEL ANDREWS | | | | 2. Date of Death Month <u>July</u> Day <u>14</u> Year <u>1999</u> | | | | 3. Time of Death <u>2:40 PM</u> | | |
| | 4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL | | | | 4b. City, Town, or Location of Death HAGERSTOWN | | | | 4c. County of Death WASHINGTON | | |
| Funeral Director | 5. Social Security Number 214-09-4493 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | |
| | Usual Residence of Decedent | | 10a. State WV | | 10b. County BERKELEY | | 10c. City, Town or Location MARTINSBURG | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 497 SCRABBLE ROAD | | 10f. Zip Code 25401 | | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 5/42 TO 10/45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRIVER | | 16b. Kind of Business/Industry HESSE OIL COMPANY | | 17. Father's Name (First, Middle, Last) FREDERICK ANDREWS | | 18. Mother's Name (First, Middle, Maiden Surname) MARY BOWERS | |
| 19a. Informant's Name/Relationship (Type, Print) HILDA ANDREWS/WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 497 SCRABBLE RD., MARTINSBURG, WV 25401 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) FALLING WATERS PRESBYTERIAN CHURCH CEMETERY | | Date 7/17/99 | | 20c. Location - City or Town, State HEDGESVILLE, WV | |
| 21. Signature of Funeral Service Licensee Charles M. Brown | | 22. Name and Address of Facility BROWN FUNERAL HOME, 327 W. KING ST. P. O. BOX 821, MARTINSBURG, WV 25402 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Coronary artery disease Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death years years | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Lung disease Kidney disease Diabetes Mellitus | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. Signature and title of certifier W.S. Hood MD | | 29c. License number D21400 | | 29d. Date signed (Month, Day, Year) 7-14-99 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W.S. Hood MD, 248 Mill St., Hagerstown, Md. 21740 | | 31. Date filed (Month, Day, Year) JUL 16 1999 | | 32. Registrar's Signature B. Sparks | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24036

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Ralph Daniel Bartles, Sr.

2. Date of Death

July-15-1999

3. Time of Death

1145AM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington Co.

5. Social Security Number

220-18-1814

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 13, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington County

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10729 Oak Forest Drive

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1946-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Checker

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Herman Samuel Bartles

18. Mother's Name (First, Middle, Maiden Surname)

Mary C. Hamby

19a. Informant's Name/Relationship (Type, Print)

Etta Louise Slayman Bartles, Wife 10729 Oak Forest Drive, Hagerstown, Maryland 21740

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Memorial Park July 19

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Kelly A. Zimmerman

22. Name and Address of Facility

Douglas A. Fiery Funeral Home
1331 Eastern Blvd. N., Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia, Hypoxia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic obstructive lung disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

small intestine obstruction due to massive
adhesion. Renal failure
mesenteric artery stenosis malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D18127

29d. Date signed (Month, Day, Year)

7/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.C. Sullivan MD, 370 Mill St. Hagerstown Md 21740

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

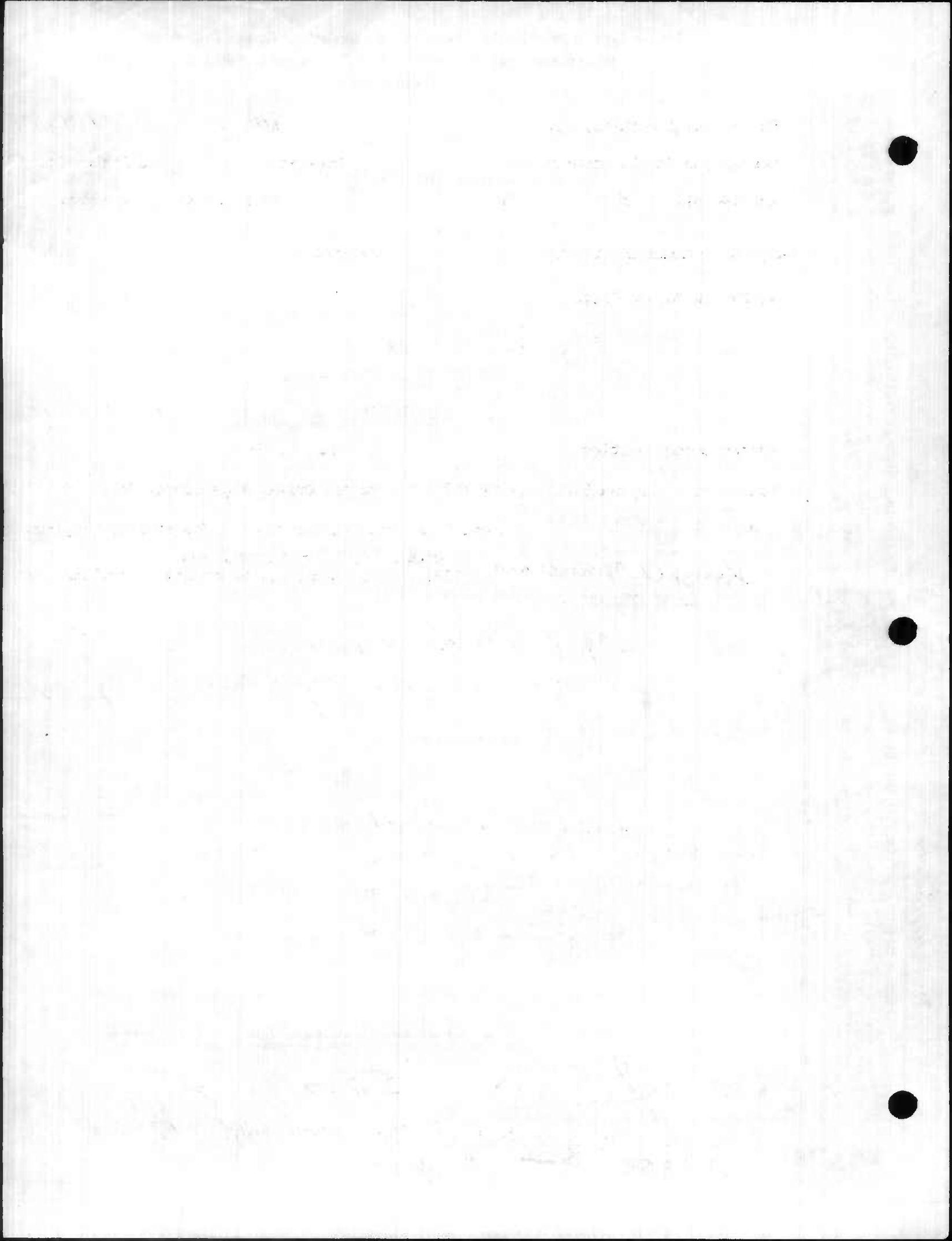
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24037

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STEPHANIE SUROWITCH BAUK

2. Date of Death

Day Year
July 15, 1999

3. Time of Death

4:40 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

REEDERS MEMORIAL HOME

4b. City, Town, or Location of Death

BOONSBORO

4c. County of Death

WASHINGTON

5. Social Security Number

150-18-2136

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
FEB. 14, 1916

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

141 SOUTH MAIN STREET

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOSTESS

16b. Kind of Business/Industry

PUBLIC MUSEUM

17. Father's Name (First, Middle, Last)

JOSEPH SUROWITCH

18. Mother's Name (First, Middle, Maiden Surname)

MARY DZIOBKO

19a. Informant's Name/Relationship (Type, Print)

THOMAS BAUK/GRANDSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8635 PETE WILES ROAD, MIDDLETOWN, MARYLAND 21769

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SMITHSBURG CREMATORY

Date

7/15/99

20c. Location - City or Town, State

SMITHSBURG, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike

Boonsboro, Maryland 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute myocardial infarction

Due to (or as a consequence of):

b.

Atherosclerosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4 Hrs

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44996

29d. Date signed (Month, Day, Year)

July 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713/ 301-432-8470

State
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

ORIGINAL

Name: Stephanie Bauk

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

99 24038

Page 1 of 1

Subject: [Illegible]

Date: [Illegible]

Location: [Illegible]

Time: [Illegible]

By: [Illegible]

For: [Illegible]

Signature: [Illegible]

Initials: [Illegible]

Witness: [Illegible]

Notary Public: [Illegible]

State of [Illegible]

County of [Illegible]

2000

Notary Public

[Illegible]

Witness

Signature of [Illegible]

Signature of [Illegible]

Signature of [Illegible]

Signature of [Illegible]

Notary Public

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Benedict Joseph Buckle Sr.

2. Date of Death

Month
JulyDay
19,Year
1999

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

14024 Oakland Rd

4b. City, Town, or Location of Death

Ridgely

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

215-26-5752

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 17, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Ridgely

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Hog Lot Rd

10f. Zip Code

21640

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1950-59

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking

17. Father's Name (First, Middle, Last)

Reuben Buckle

18. Mother's Name (First, Middle, Maiden Surname)

Eva Tribbitt

19a. Informant's Name/Relationship (Type, Print)

Mary Margaret Kitchen/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10506 Orly Drive Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ridgely Cemetery

Date

July 22, 1999

20c. Location - City or Town, State

Ridgely, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home PA

PO Box 160 Greensboro, Maryland 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. *Metastatic adenocarcinoma*
Due to (or as a consequence of): *unknown primary*Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D51639

29d. Date signed (Month, Day, Year)

7/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caren Moffett Daffin Ln Denton, Maryland 21629

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

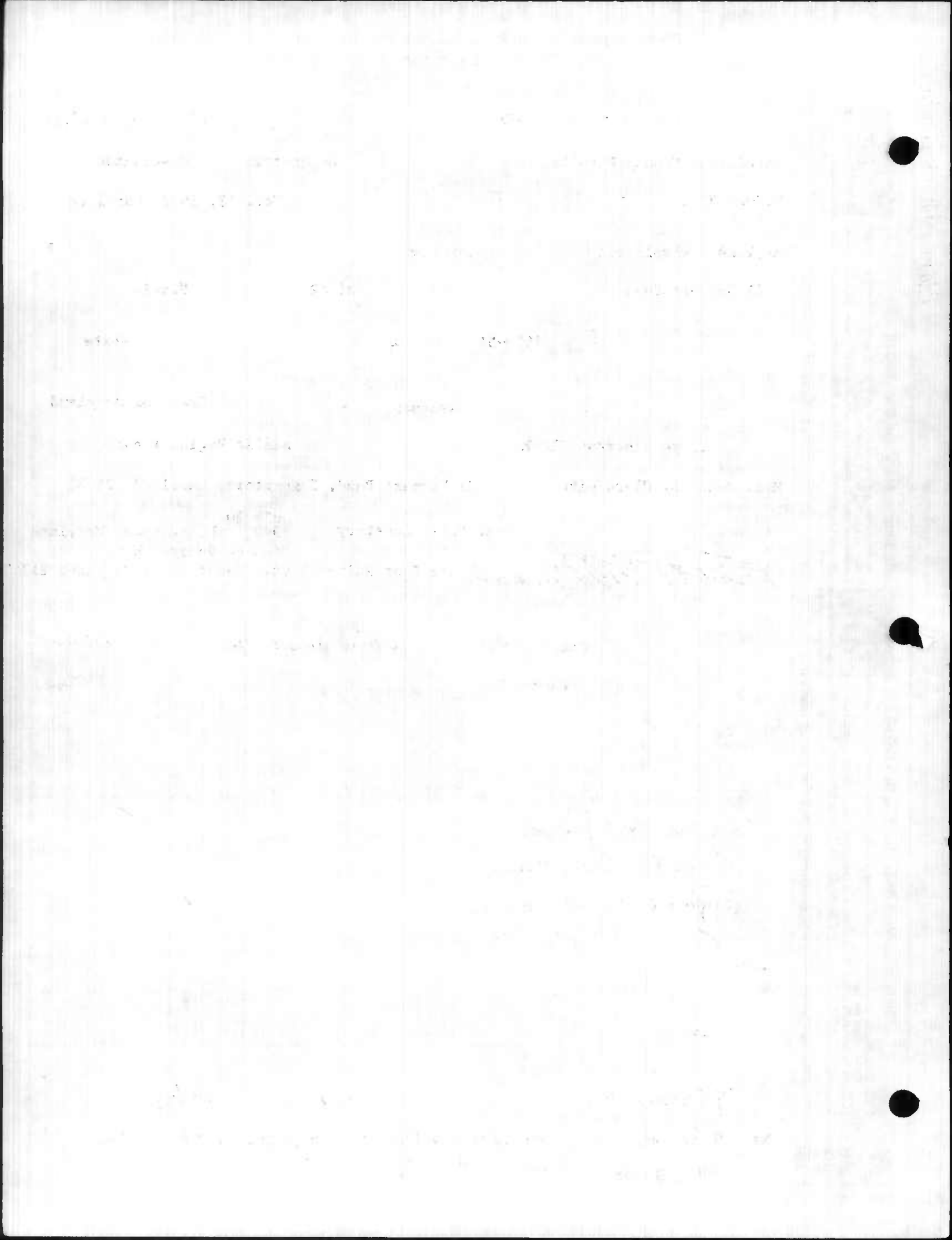
State of Maryland / Department of Health and Mental Hygiene

99 24040

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Franklin CLARK | | | | 2. Date of Death Month Day Year July 17, 1999 | | 3. Time of Death 6:27 PM | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 213-24-9828 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 13, 1928 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 131 Harvard Road | | 10f. Zip Code 21742 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1950-51 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) assessor | | 16b. Kind of Business/Industry State of Maryland | | 17. Father's Name (First, Middle, Last) Lloyd Albertus Clark | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Mellie Regina Fisher | | 19a. Informant's Name/Relationship (Type, Print) Mrs. Joann B. Clark/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 Harvard Road, Hagerstown, Maryland 21742 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| Physician /Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | 20c. Date July 20 1999 | | 20d. Location - City or Town, State Hagerstown, Maryland | | 21. Signature of Funeral Service Licensee <i>Scott M. Minnick</i> | |
| | 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. <i>Electromechanical cardiac dissociation</i> Due to (or as a consequence of): f. <i>Peritonitis</i> Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 20 mins 2 days | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| State Registrar | 29b. Signature and title of certifier <i>K. Strauss MD</i> | | 29c. License number DD0047234 | | 29d. Date signed (Month, Day, Year) 7/12/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelli A Strauss MD 747 Northern Avenue Hagerstown MD 21742 | |
| | 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature <i>Barbara S. Sparks</i> | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24041

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mark Joseph Case

2. Date of Death

Month Day Year
July 15 1999

3. Time of Death

2:45 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice Center

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

220-34-6353

6. Sex

XX ☐ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 21 1918

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

11 Wimert Avenue

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married ☐ Married
3 ☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Edward W. Case

18. Mother's Name (First, Middle, Maiden Surname)

Emma Yingling

19a. Informant's Name/Relationship (Type, Print)

R. Kyle Pritts Jr. - Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 Washington Road

Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial ☐ Cremation ☐ Removal from State
4 ☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. John Catholic Cem

20c. Location - City or Town, State

Westminster, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home and Chapel

412 Washington Road Westminster, MD

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural ☐ Pending
Investigation
2 ☐ Accident ☐ Suicide
3 ☐ Suicide ☐ Could not be
determined
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/16/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

B. Sparks

State
Registrar

MARK CASE July 15, 1999 3:10 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24042

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|-------------------------------------|---|--|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Donald Raymond CATTS, Sr. | | | | 2. Date of Death Month Day Year July 17, 1999 | | | | 3. Time of Death 12:44 am | |
| | 4a. Facility Name (If not institution, give street and number) University of MD Medical System | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death - | |
| Funeral Director | 5. Social Security Number 213 40 9646 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) March 3, 1941 | | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Calvert | | 10c. City, Town or Location Owings | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 2065 Clearview Drive | | 10f. Zip Code 20736 | | 10g. Citizen of What Country? USA | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self-empl. electronics technician | |
| | 16b. Kind of Business/Industry Electronics | | 17. Father's Name (First, Middle, Last) Raymond Dulaney Catts | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Rita Marshall | | 19a. Informant's Name/Relationship (Type, Print) Margie Catts (wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 7-18-99 | | 20c. Location - City or Town, State Alexandria, VA | | 21. Signature of Funeral Service Licenses | |
| | 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. METASTATIC LUNG CANCER Due to (or as a consequence of): f. LARGE CELL CARCINOMA Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE PNEUMONIA | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Paul Bryan Roach M.D. | | 29c. License number 12458 | | 29d. Date signed (Month, Day, Year) July 17, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PAUL ROACH M.D. 22 S. GREENE ST. BALTIMORE MD 21201 | | 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature B. Sparks | | State Registrar | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24043

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sara Jane DeLauter | | | | 2. Date of Death Month JULY Day 11 Year 1999 | | 3. Time of Death 0215 | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 219-34-5204 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 60 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 23, 1938 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Md. | | 10b. County Frederick | | 10c. City, Town or Location Smithsburg | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 12801 Wolfsville Rd. | | | | 10f. Zip Code 21783 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | 16b. Kind of Business/Industry School Board | | |
| 17. Father's Name (First, Middle, Last) George Shantz | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Yeager | | | |
| 19a. Informant's Name/Relationship (Type, Print) Clark D. Delauter (Husband) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Wolfsville Rd. Smithsburg, Md. 21783 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory | | Date July 13, 1999 | | 20c. Location - City or Town, State Smithsburg, Md. | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | 29c. License number D53498 | | 29d. Date signed (Month, Day, Year) JULY 13, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leo F. Kenzowski, MD 3019 Ventrie Court Myersville, MD 21773 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 13 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

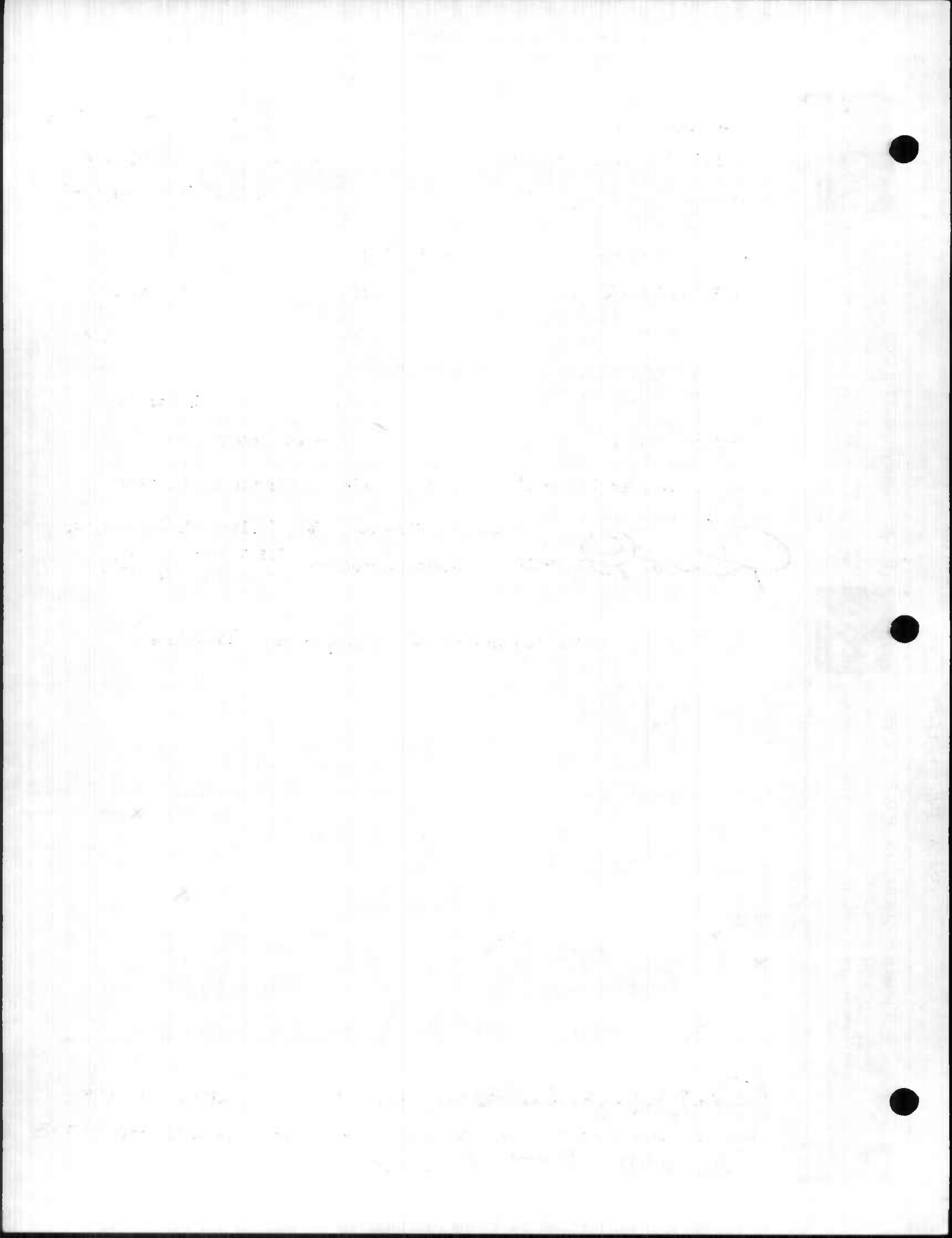
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

SARA JANE DELAUTER



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24044

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Marie Nancy Dahlhamer

2. Date of Death

07 10 '99

3. Time of Death

2105

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

212-24-2889

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 22, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13824 Paradise Church Road

10f. Zip Code

21742

10g. Citizen of What Country?

u.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0-12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

owner/operator

16b. Kind of Business/Industry

antique shop

17. Father's Name (First, Middle, Last)

Roscoe C. Ahalt

18. Mother's Name (First, Middle, Maiden Surname)

Clara Pearl

19a. Informant's Name/Relationship (Type, Print)

Mr. George E. Dahlhamer/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13824 Paradise Church Road, Hagerstown, Maryland

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hagerstown Crematory

Date

July 11,
1999

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Minnich Funeral Home

415 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Adenocarcinoma of left Breast with 23 years
Due to (or as a consequence of):
b. widespread metastases
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Robert Brull MD personal physician

29c. License number

D04359

29d. Date signed (Month, Day, Year)

July 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Brull

1459 Potomac Ave. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

JUL 13 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitDahlhamer, Marie Nancy Ahalt
Division of Vital Records, P.O. Box 68760,

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

CJ
Maurice Duray
Dickson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24045

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Maurice Duray Dickson | | | | 2. Date of Death Month Day Year July 18 1999 | | 3. Time of Death 03:08 PM. | |
| | 4a. Facility Name (If not institution, give street and number) Interstate 70 1/2 East of Interstate 81 | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 219-82-7403 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 28 Yrs. | | 8. Date of Birth (Month, Day, Year) May 29, 1971 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 248 Frederick Street | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) handyman | | 16b. Kind of Business/Industry self | | | | |
| 17. Father's Name (First, Middle, Last) Lawrence Allen Dickson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Diane Armatha Henderson | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lawrence A. Dickson Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Frederick Street Hagerstown, Maryland 21740 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery | | 20c. Date 7/22/99 | | 20d. Location - City or Town, State Hagerstown, Maryland | | |
| 21. Signature of Funeral Service Licensee Gerald N. Minnich | | | | 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7-18-99 | | 28b. Time of Injury 1411 PM | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred motorcycle accident | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) I-70 Washington Co., Md | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Dennis J. Chuteau | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) July 19, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chuteau 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

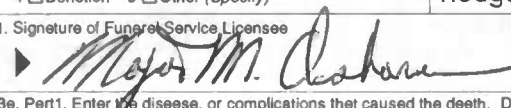
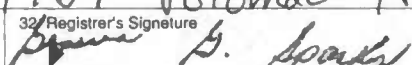
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24046

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ethel Jane DAVIS | | | | 2. Date of Death Month July Day 9 Year 1999 | | 3. Time of Death 2345 | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death WASHINGTON | |
| Funeral Director | 5. Social Security Number 235-30-2978 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jun. 28, 1922 | 9. Birthplace (State or Foreign Country) West Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Washington | | 10c. City, Town or Location Funkstown | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 4 Frederick Rd. | | | | 10f. Zip Code 21734 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lic. Day-Care Provider | | | 16b. Kind of Business/Industry Home Care | |
| 17. Father's Name (First, Middle, Last) William Lemen Avey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cora Cleveland Ashton | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Kenneth G. Davis, Jr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15422 Fairview Rd. Hagerstown, MD 21740 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hedgesville Cemetery Jul. 13, 1999 | | 20c. Location - City or Town, State Hedgesville, WV | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility OSBORNE FUNERAL HOME P.O. Box # 348 Williamsport, MD 21795 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Progressive Pulmonary fibrosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 10 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Robert Bull M.D. - personal physician | | 29c. License number DO4359 | | 29d. Date signed (Month, Day, Year) July 10 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Bull 1459 Potomac Ave. Hagerstown, Md 21742 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 13 1999 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

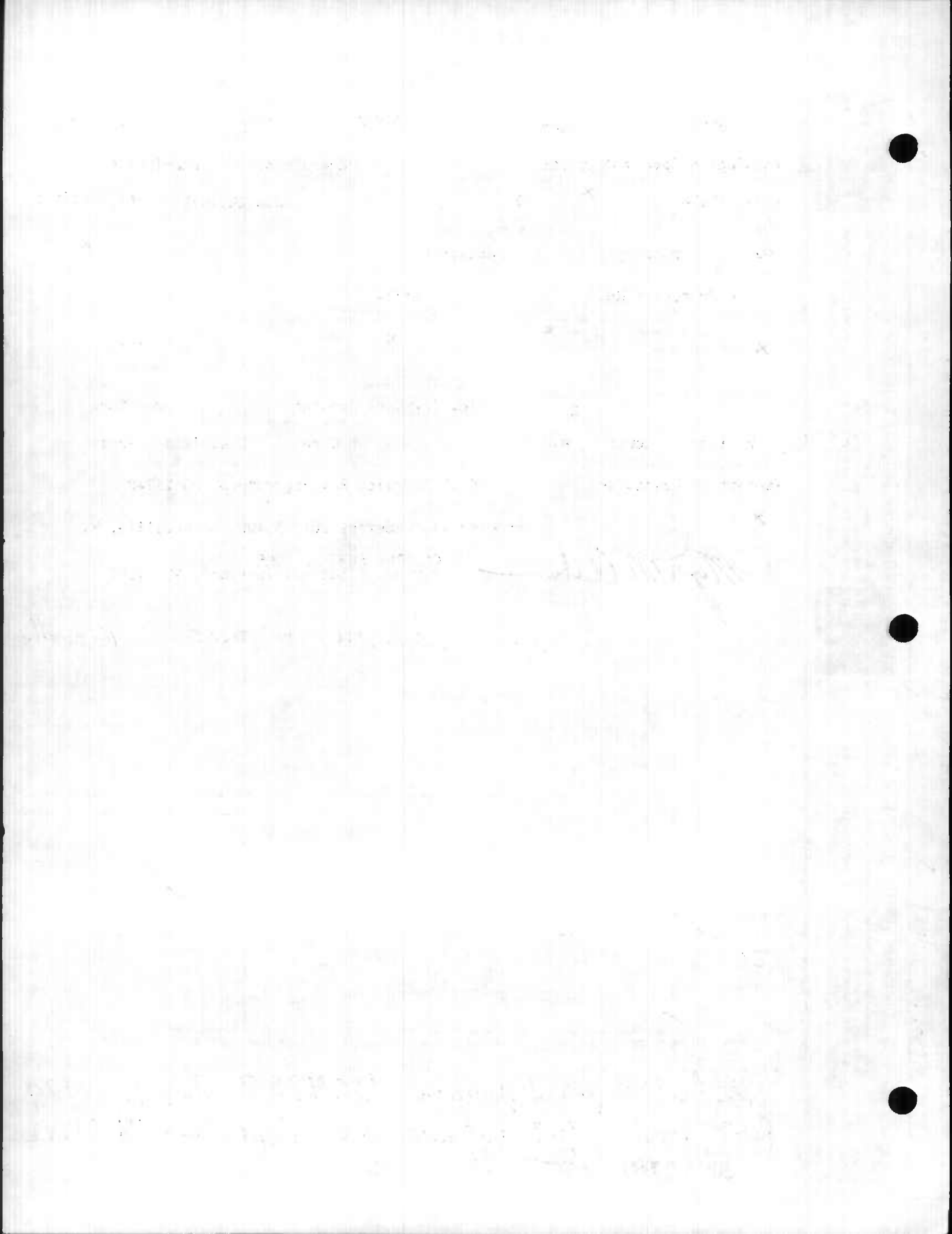
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Davis, Ethel J



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24047

| | | | | | | | | |
|---|--|--|---|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NAGINDAS DOSHI | | | | 2. Date of Death Month Day Year JULY 17, 1999 | | 3. Time of Death 9:35 AM | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | |
| Funeral Director | 5. Social Security Number 220-53-9243 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 12, 1927 | |
| | 9. Birthplace (State or Foreign Country) India | | 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Union Bridge | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 12803 Boxwood Ct. | | 10f. Zip Code 21791 | | 10g. Citizen of What Country? India | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Indian | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) manager | | 16b. Kind of Business/Industry dairy products | | | |
| | 17. Father's Name (First, Middle, Last) Harjivandas Doshi | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Maniben Kamdar | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Manoramaben Doshi/ wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12803 Boxwood Ct. Union Bridge, MD 21791 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Davis Crematory | | Date 7/18/99 | | 20c. Location - City or Town, State Smithsburg, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>Catherine D. Hartzler</i> | | | | 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Pancreatic Cancer</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death <i>months</i> |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier <i>A-Z. HEGAZI, MD</i> | | | | 29c. License number <i>D44164</i> | | 29d. Date signed (Month, Day, Year) <i>7-17-1999</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>A-Z. HEGAZI, MD 801 TOLLHOUSE D-3 21701 Frederick, MD</i> | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <i>JUL 19 1999</i> | | | | 32. Registrar's Signature <i>Bevera B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24048

| | | | | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jeanne E. Donovan | | | | 2. Date of Death Month Day Year July 13, 1999 | | | | 3. Time of Death 10:07 PM | |
| | 4a. Facility Name (If not institution, give street and number) Robosson Nursing Center | | | | 4b. City, Town, or Location of Death Randallstown | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 168-26-8074 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) April 15 1937 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location Woodbine | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10a. State Maryland | | 10b. County Carroll | | 10f. Zip Code 21797 | | | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bon Secor Hospital | | | | 16b. Kind of Business/Industry Radiology | | |
| 17. Father's Name (First, Middle, Last) Vern O'Leary | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth O'Leary | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Cynthia Szymanski (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 Dorsey Lane Woodbine, MD 21797 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Johns Cemetery | | Date Jul. 15, 1999 | | 20c. Location - City or Town, State Ellicott City, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 W. Old Liberty Rd. Winfield, MD 21784 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | |
| e. Sepsis | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| b. Pneumonia | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| c. | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| d. | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| Cerebral vascular Accident. | | | | | | | | | | |
| Breast Cancer | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 029085 | | 29d. Date signed (Month, Day, Year) July 15 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Allen J. Chincus M.D. 5310 Old Court Rd 21133 Randallstown, MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | 32. Registrar's Signature  | | | | | | | | |

To Be Completed by Funeral Director

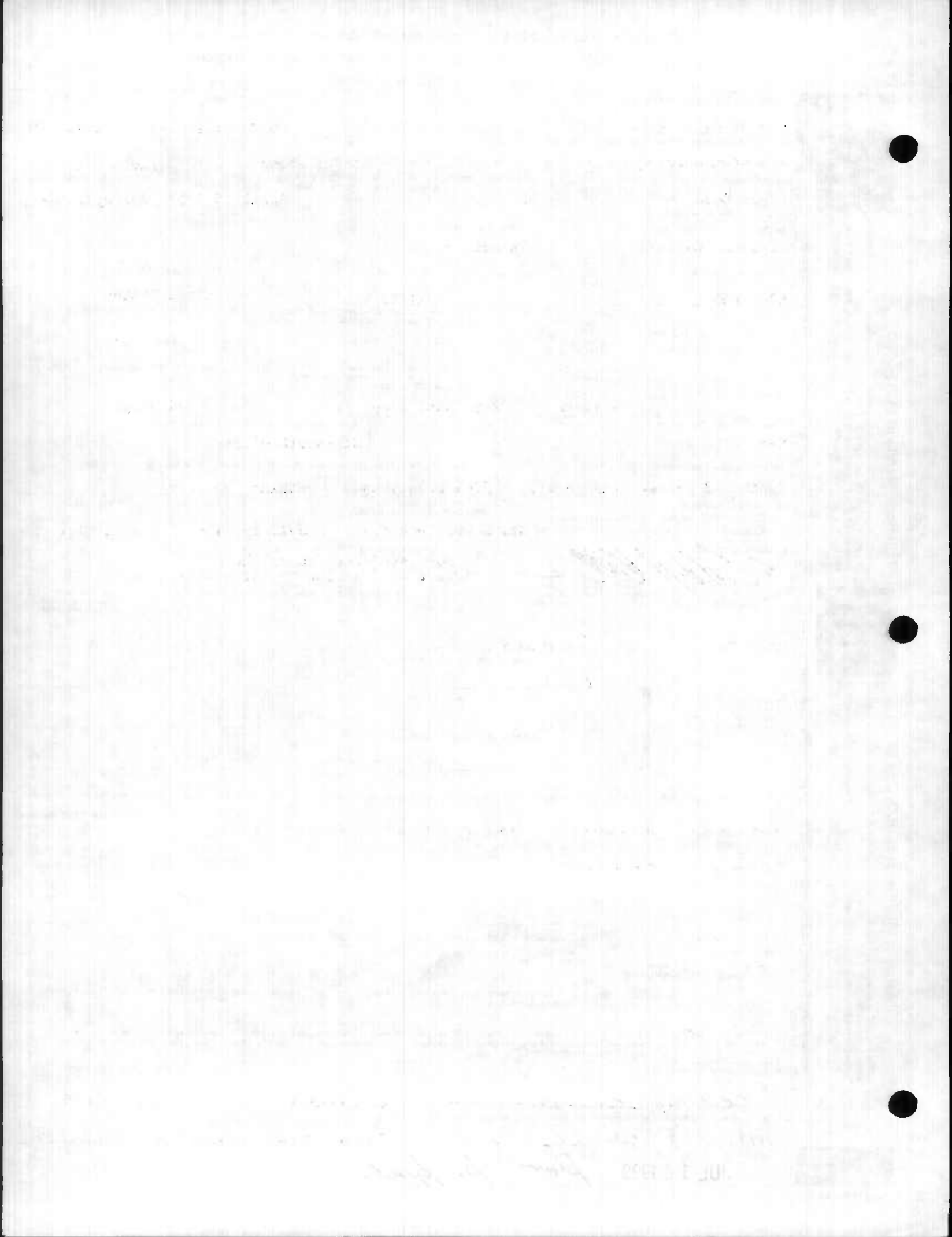
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) <i>Mary Catherine Dalton</i> | | | | 2. Date of Death Month <i>July</i> Day <i>15</i> Year <i>1999</i> | | | | 3. Time of Death <i>11 AM</i> | | | | | |
| 4a. Facility Name (If not institution, give street and number) 6 D Bridgelake Circle | | | | 4b. City, Town, or Location of Death Cockeysville | | | | 4c. County of Death Baltimore | | | | | |
| 5. Social Security Number 212-52-4546 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 40 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) 9/5/58 | | 9. Birthplace (State or Foreign Country) MD | |
| Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Cockeysville | | | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 6 D Bridgelake Circle | | | | 10f. Zip Code 21030 | | | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Headhunter | | | | 16b. Kind of Business/Industry Car Rental | | | | | |
| 17. Father's Name (First, Middle, Last) Edmund Nugent Dalton | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Redman | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Edmund Dalton/ Father | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 Abbeyshire Lane Berlin, MD 21811 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Churchyard St. Paul's Episcopal | | Date 7/18/99 | | 20c. Location - City or Town, State Berlin, MD | | | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | | | 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Occlusion Due to (or as a consequence of): Arteriosclerotic CardioRenal Vascular Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Diabetes Mellitus | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Charles F. O'Donnell MD</i> | | | | | | 29c. License number D-09383 | | | 29d. Date signed (Month, Day, Year) July 15, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles F. O'Donnell MD 111 Hamlet Hill Rd Baltimore Md 21210 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

100-100

100-100

100-100

100-100

100-100

100-100

100-100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24050

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Joseph Francis Driscoll

2. Date of Death

Month Day Year
July 14, 1999 9:30 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

ST. JOSEPH HOSPITAL

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

081-18-1436

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
02-14-1922

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

MILLSBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

49 DERBY WAY

10f. Zip Code

19966

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

PRINTER

16b. Kind of Business/Industry

RAILROAD

17. Father's Name (First, Middle, Last)

DANIEL DRISCOLL

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET TIERNEY

19a. Informant's Name/Relationship (Type, Print)

MARTHA J. DRISCOLL/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

49 DERBY WAY, MILLSBORO, DELAWARE. 19966

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DELAWARE VETERANS MEMORIAL 7-20-99 BEAR, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MELSON FUNERAL SERVICES, LTD.
LONG NECK ROAD, MILLSBORO, DELAWARE. 19966

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Occlusion

Due to (or as a consequence of):

b. Arteriosclerotic Cardio Vascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. O'Donnell MD Baltimore MD 21210

31. Date filed (Month, Day, Year)

JUL 22 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1015 33 JUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24051

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>William B. Elliott</u> | | | | 2. Date of Death Month <u>July</u> Day <u>18th</u> Year <u>1999</u> | | 3. Time of Death <u>0356</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Atlantic General Hospital</u> | | | | 4b. City, Town, or Location of Death <u>Berlin</u> | | 4c. County of Death <u>Worcester</u> | |
| Funeral Director | 5. Social Security Number <u>217 30 9760</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>61</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>Dec. 14, 1937</u> | |
| | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | 10a. State <u>Maryland</u> | | 10b. County <u>Worcester</u> | | 10c. City, Town or Location <u>Berlin</u> | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number <u>9031 Stephen Decatur Highway</u> | | 10f. Zip Code <u>21811</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Policeman</u> | | 16b. Kind of Business/Industry <u>Law Enforcement</u> | | | | |
| 17. Father's Name (First, Middle, Last) <u>Ebe Burton Elliott, Sr.</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Eunice Burbage Jarvis</u> | | 19a. Informant's Name/Relationship (Type, Print) <u>Sallie Tilghman Elliott</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9031 Stephen Decatur Hwy. Berlin, MD 21811</u> | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cape Henlopen Crematory</u> | | 20c. Location - City or Town, State <u>Frankford, DE</u> | | 20d. Date <u>7/18/99</u> | | |
| 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | 22. Name and Address of Facility <u>Burbage Funeral Home</u> | | 22b. City or Town, State, Zip Code <u>Berlin, MD 21811</u> | | 22c. Date <u>7/18/99</u> | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. congestive heart failure</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>b.</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u> | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) <u>7/18/99</u> | | |
| 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>[Signature]</u> <u>physician</u> | | 29c. License number <u>H44283</u> | | 29d. Date signed (Month, Day, Year) <u>7/18/99</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Robert J. Durkin DO. 9733 HEATHWAY DR. BERLIN MD</u> | | 31. Date filed (Month, Day, Year) <u>JUL 19 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Handwritten signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24052

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THEODORE WILLIAM GOSSARD

2. Date of Death

Month Day Year
JULY 11 1999

3. Time of Death

9:40 pm

4a. Facility Name (If not institution, give street and number)

119 Dartmouth Drive

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

216-54-7911

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 30, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

119 Dartmouth Drive

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Medical Transport

17. Father's Name (First, Middle, Last)

Clarence William Gossard

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Louise Mellott

19e. Informant's Name/Relationship (Type, Print)

Tina M. Gossard/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 Dartmouth Drive Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Memorial Park 7-15-99 Hagerstown, Maryland

21. Signature of Funeral Service Director

22. Name and Address of Facility

Osborne Funeral Home

425 S. Conococheague St. Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE RENAL DISEASE

Due to (or as a consequence of):

b. RENAL FAILURE

Due to (or as a consequence of):

c. GLOMERULONEPHRITIS

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

14 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PATIENT STOPPED HEALING 72.95

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D 13713

29d. Date signed (Month, Day, Year)

7. 12 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OTTO ROZA MD 12931 DAK HILL AV HAGERSTOWN MD 21742

31. Date filed (Month, Day, Year)

JUL 13 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first of these is the fact that the
the first of these is the fact that the
the first of these is the fact that the
the first of these is the fact that the
the first of these is the fact that the

2. The second of these is the fact that the
the second of these is the fact that the
the second of these is the fact that the
the second of these is the fact that the
the second of these is the fact that the

3. The third of these is the fact that the
the third of these is the fact that the
the third of these is the fact that the
the third of these is the fact that the
the third of these is the fact that the

4. The fourth of these is the fact that the
the fourth of these is the fact that the
the fourth of these is the fact that the
the fourth of these is the fact that the
the fourth of these is the fact that the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24053

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Juanita Virginia Grimm | | | | 2. Date of Death Month July Day 19 Year 1999 | | 3. Time of Death 0142 | |
| 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| 5. Social Security Number 236-40-7836 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JAN. 29, 1928 | |
| 9. Birthplace (State or Foreign Country) WEST VIRGINIA | | | | | | | |
| 10a. State MARYLAND | | 10b. County WASHINGTON | | 10c. City, Town or Location HAGERSTOWN | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 11311 LAKESIDE DRIVE | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | |
| 17. Father's Name (First, Middle, Last) RAYMOND HENRY FRAZIER SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) MELLIE BLANCHE HAINES | | | |
| 19a. Informant's Name/Relationship (Type, Print) PATRICIA A. SHANK/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 185 FRONT DRIVE, WINCHESTER, VIRGINIA 22602 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR LAWN MEM. PARK | | Date 7/22/99 | | 20c. Location - City or Town, State HAGERSTOWN, MARYLAND | |
| 21. Signature of Funeral Service Licensee  Paul M. Dean | | | | 22. Name and Address of Facility BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713 | | | |
| 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Catheter infection Due to (or as a consequence of): c. Hyperalimentation dependence Due to (or as a consequence of): d. Small bowel enterocutaneous fistulas | | | | | | | |
| Approximate Interval Between Onset and Death e. few days b. few days c. 9 months d. 9 months | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Steroid dependent chronic obstructive pulmonary disease - Nutritional depletion - Obesity - Hypertension - Ventral fascial defect - Anxiety - Depression | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier  medical doctor | | | | 29c. License number D46081 | | 29d. Date signed (Month, Day, Year) July 20 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank J Collins md 340 mill street Hagerstown md 21740 | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitpermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24054

| | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lena Genevieve Gamby | | | | 2. Date of Death Month Day Year July 8 1999 | | | | 3. Time of Death 0600 | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 189-07-8607 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 11, 1910 | | 9. Birthplace (State or Foreign Country) Penna. | |
| | Usual Residence of Decedent | | | | 10a. State Md. | | 10b. County Washington | | 10c. City, Town or Location Boonsboro | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 8507 Mapleville Rd. | | | | 10f. Zip Code 21713 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress | | | | 16b. Kind of Business/Industry Garment Mfg. | | | | 17. Father's Name (First, Middle, Last) Newton Isaac Bingaman | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Emma Lucetta Kessler | | | | 19a. Informant's Name/Relationship (Type, Print) Larry R. Gamby/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9937 White Hall Rd. Hagerstown, Md. 21740 | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Gardens | | | | 20c. Location - City or Town, State Chambersburg, Pa. | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee H. Martin Zimmerman | | | | 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Cynthia Kuttner-Sands, MD | | | | 29c. License number D47451 | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) July 08, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Cynthia Kuttner-Sands, MD 1110 Medical Campus Road Hagerstown, Maryland | | | | 31. Date filed (Month, Day, Year) JUL 09 1999 | |
| | 32. Registrar's Signature S. Sparks | | | | 32. Registrar's Signature S. Sparks | | | | 32. Registrar's Signature S. Sparks | |

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

1931

1932

1933

1934

1935

1936

1937

1938

1939

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24055

Certificate of Death

Reg. No.

CHARLES AXLEY GRAHAM
Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

| | | | | | | | | | |
|---|---|---|--|--|---|---|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles Axley Graham | | | | 2. Date of Death Month Day Year JULY 14, 1999 | | 3. Time of Death 11:55 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Carroll County General Hospital | | | | 4b. City, Town, or Location of Death Westminster | | 4c. County of Death Carroll | | |
| Funeral Director | 5. Social Security Number 226-18-6373 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 1, 1916 | | |
| | 9. Birthplace (State or Foreign Country) Virginia | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location New Windsor | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 302 College Ave. | | | | 10f. Zip Code 21776 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mechanic | | 16b. Kind of Business/Industry automobile service center | | | |
| 17. Father's Name (First, Middle, Last) John Ranson Graham | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Anderson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ora A. Graham/ wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 College Ave. New Windsor, MD 21776 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Branch Cemetery | | Date 7/17/99 | | 20c. Location - City or Town, State Westminster, MD | | | |
| 21. Signature of Funeral Service Licensee Catherine D. Hartzler | | | | 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 6 hours 0 hours | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier D. H. Schaeffer, MD | | | | 29c. License number DZ8221 | | 29d. Date signed (Month, Day, Year) July 14, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAN H. SCHAEFFER, MD 200 Memorial Avenue, Westminster, MD 21157 CARROLL COUNTY GENERAL HOSPITAL | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24056

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY S. GLADDEN

2. Date of Death

Month Day Year
July 16 1999

3. Time of Death

0531

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

217-30-8393

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
09-04-1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

FRUITLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

114 HAYWARD AVENUE

10f. Zip Code

21826

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
2

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LICENSED PRACTICAL NURSE

16b. Kind of Business/Industry

HEALTHCARE

17. Father's Name (First, Middle, Last)

MONTGOMERY STAGG

18. Mother's Name (First, Middle, Maiden Surname)

ELEANOR JOHNSON

19a. Informant's Name/Relationship (Type, Print)

EDWARD M. GLADDEN/ HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 HAYWARD AVE., FRUITLAND, MD. 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SPRINGHILL MEMORY GARDEN 7-20-99

Date

20c. Location - City or Town, State

HEBRON, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MELSON FUNERAL SERVICES, LTD.

43 THATCHER STREET, FRANKFORD, DELAWARE. 19945

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

non-insulin dependent diabetes mellitus
past history of cerebrovascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Rodney A. Wernich, M.D.

29c. License number

D15384

29d. Date signed (Month, Day, Year)

July 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RODNEY A. WERNICH

100 POWER STREET

SALISBURY MD. 21804

31. Date filed (Month, Day, Year)

JUL 22 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Mary E. Gladden 217-30-8393

March 17, 1954

Dear Mr. Tolson

Dear Mr. Boardman

Dear Mr. Clegg

Dear Mr. Glavin

Dear Mr. Ladd

Dear Mr. Nichols

Dear Mr. Rosen

Dear Mr. Tracy

Dear Mr. Harbo

Dear Mr. Mohr

Dear Mr. Winterrowd

Dear Mr. Holloman

Dear Mr. Pennington

Dear Mr. Egan

Dear Mr. Gurnea

Dear Mr. Hendon

Dear Mr. Jones

Dear Mr. Mumford

Dear Mr. Quinn

Dear Mr. Nease

Dear Mr. Gandy

Dear Mr. Egan

Dear Mr. Gurnea

Dear Mr. Jones

Dear Mr. Mumford

Dear Mr. Quinn

Dear Mr. Nease

Dear Mr. Gandy

Dear Mr. Egan

Dear Mr. Gurnea

Dear Mr. Jones

Dear Mr. Mumford

Dear Mr. Quinn

Dear Mr. Nease

Very truly yours,
J. Edgar Hoover

BRE: S S: JAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24057

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Adeline B. Garrett

2. Date of Death

Month Day Year
July 24, 1999

3. Time of Death

11:20 PM

4a. Facility Name (If not institution, give street and number)

Herman Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

220-44-9462

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Feb. 3, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

301 Russell Ave.

10f. Zip Code

20877

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Dawes Garrett/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

640 S. Pine St., Arlington Heights, IL 60005

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Yorktowne Caskets, Inc. July 27,
Cremation Service 1999

Date

20c. Location - City or Town, State

York, PA 17404

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc.
24 Second St., New Freedom, PA 1734923a. Part I. Enter the disease, or combination that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Congestive heart failure
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

year

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. mitral regurgitation
Due to (or as a consequence of):

year,

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hemochromatosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D19294

29d. Date signed (Month, Day, Year)

July 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN R. MELNICK 911 RUSSELL AVE GAITHERSBURG, Md. 20879

31. Date filed (Month, Day, Year)

JUL 30 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
- within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

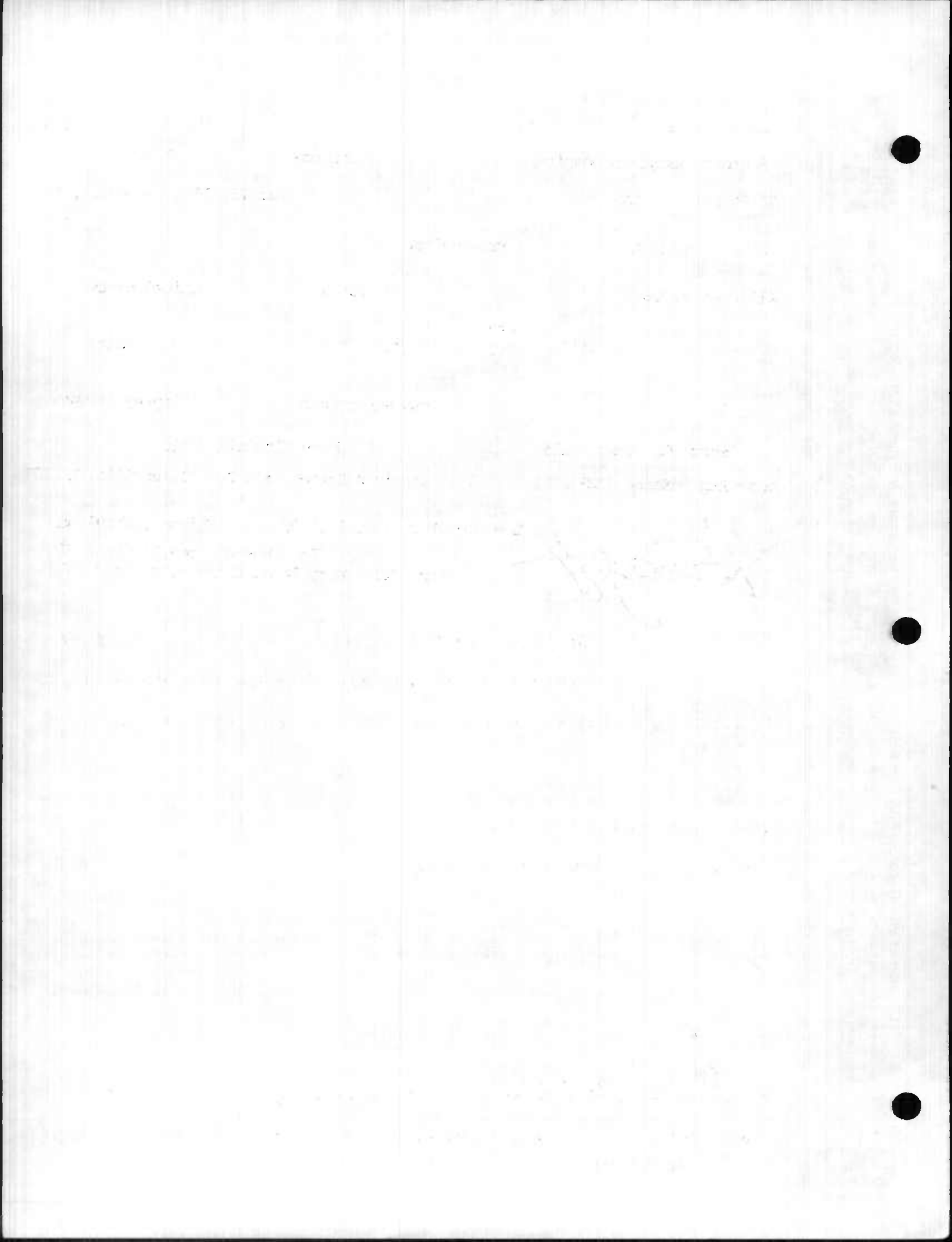
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24058

| | | | | | | | | | | |
|---|--|--|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Donald J Gould | | | | 2. Date of Death Month July Day 16 Year 1999 | | | | 3. Time of Death 10:17am | |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death Clinton | | | | 4c. County of Death P.G. | |
| Funeral Director | 5. Social Security Number 578 52 2713 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F XX | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec 25, 1934 | | 9. Birthplace (State or Foreign Country) Scranton, PA | |
| | Usual Residence of Decedent | | | | 10a. State MD | | | | 10b. County P.G. | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Brandywine | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number 8411 Boundry Lane | | | | 10f. Zip Code 20613 | | | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1952 1962 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ramp Supervisor | | | | 16b. Kind of Business/Industry Allegany Airways | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) George Franices Gould | | | | 18. Mother's Name (First, Middle, Maiden Summa) Mary Virginia Doyle | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Julia Ann DuShane (PER REP) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1785 Harrison Street Unit 709, Tutusville, FL 32780 | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory | | Date July 17, 1999 | | 20c. Location - City or Town, State Clinton, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | | | | |
| Physician /Medical Examiner | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS, GENERALIZED Due to (or as a consequence of): INFECTED BILATERAL BELOW-THE KNEE STUMPS Due to (or as a consequence of): METHICILLIN-RESISTANT-STAPHYLOCOCCUS-AUREUS INFECTION Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 2 WKS 1 WK 1 WK | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | |
| | 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D-15513 (MD) | |
| State Registrar | 29d. Date signed (Month, Day, Year) 07/16/99 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUCIO S. VILLA-REAL, M.D., - #10 ST. PATRICK'S DRIVE, SUITE 502, WALDORF, MD 20603 | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 21 1999 | | | | 32. Registrar's Signature | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24059

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lenora Mae Hoffman

2. Date of Death

Month Day Year
July 9, 1999

3. Time of Death

11:29 am

4a. Facility Name (If not institution, give street and number)

Washington Co. Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

196-12-1339

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 12, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Pennsylvania

10b. County

Armstrong

10c. City, Town or Location

Dayton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

North Poplar St

10f. Zip Code

16222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Thomas McElhiney

18. Mother's Name (First, Middle, Maiden Surname)

Grace Milliron

19a. Informant's Name/Relationship (Type, Print)

Bauer-Bly Funeral Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

125 Main St. Dayton, PA. 16222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Milton Cemetery

Date

7-13-99

20c. Location - City or Town, State

Milton, PA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich Funeral Home
415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic Cardiovascular disease

Approximate Interval Between Onset and Death

10 yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01062

29d. Date signed (Month, Day, Year)

July 9, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 21740

State
Registrar

31. Date filed (Month, Day, Year)

JUL 13 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24060

AMEND ITEMS: #5, 18
#8 PER INFORMANT G775 9-1-99 WR.

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALVERTA Jane HADLEY | | 2. Date of Death Month July Day 15 Year 1999 | | 3. Time of Death 1:45 PM |
| | 4e. Facility Name (If not institution, give street and number) 2112 Westfield Avenue | | 4b. City, Town, or Location Baltimore | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 199-14-1736 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) MAR 6 1924 | | 9. Birthplace (State or Foreign Country) Woodbine, Pa. | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore |
| | 10e. Street and Number 2112 Westfield Avenue | | 10f. Zip Code 21214 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector | | 16b. Kind of Business/Industry Manufacturing |
| | 17. Father's Name (First, Middle, Last) David Hadley | | 18. Mother's Name (First, Middle, Maiden Surname) Alice Wailes WALES | | |
| | 19a. Informant's Name/Relationship (Type, Print) Janice Piercy, daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3368 St. Benedict Street Baltimore, Maryland 21229 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fairfield Union Cemetery | | 20c. Location - City or Town, State 7-19-99 Fairfield, Pa. |
| | 21. Signature of Funeral Service Licensee Dominic J. Davis | | 22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Disease | | | | Approximate Interval Between Onset and Death 5 years |
| | Due to (or as a consequence of): End stage Heart disease | | | | 10 years |
| To Be Completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| | 28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier Attending Physician | | 29c. License number D53642 | | 29d. Date signed (Month, Day, Year) July 16 1999 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) XIAO MING ZHOU 3007 E Northern Park way Baltimore 21214 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature B. Sparks | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24061

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Jefferson D Hooper, Jr.

2. Date of Death

Month Day Year
July 14 1999

3. Time of Death

9:25p.m.

4a. Facility Name (If not institution, give street and number)

152 Lincoln Road

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

213-10-7003

6. Sex

M 2 ☒ F

7. Age (In yrs. last birthday)

99

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 23 1900

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

152 Lincoln Road

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Barber

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Jefferson D. Hooper, Sr

18. Mother's Name (First, Middle, Maiden Surname)

Mary Byers

19a. Informant's Name/Relationship (Type, Print)

Melissa Seitz/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

152 Lincoln Road

Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Westminster Cemetery 7/17/99

20c. Location - City or Town, State

Westminster, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home and Chapel

412 Washington Rd., Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Congestive heart failure

two months

Due to (or as a consequence of):

Myocardial infarction

1997

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard G. Lanham M.D.

29c. License number

D17040

29d. Date signed (Month, Day, Year)

July 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard G. Lanham, M.D. 215 Washington Hgts Med'l Ctr, Westminster MD

21157

State
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

Beverly B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

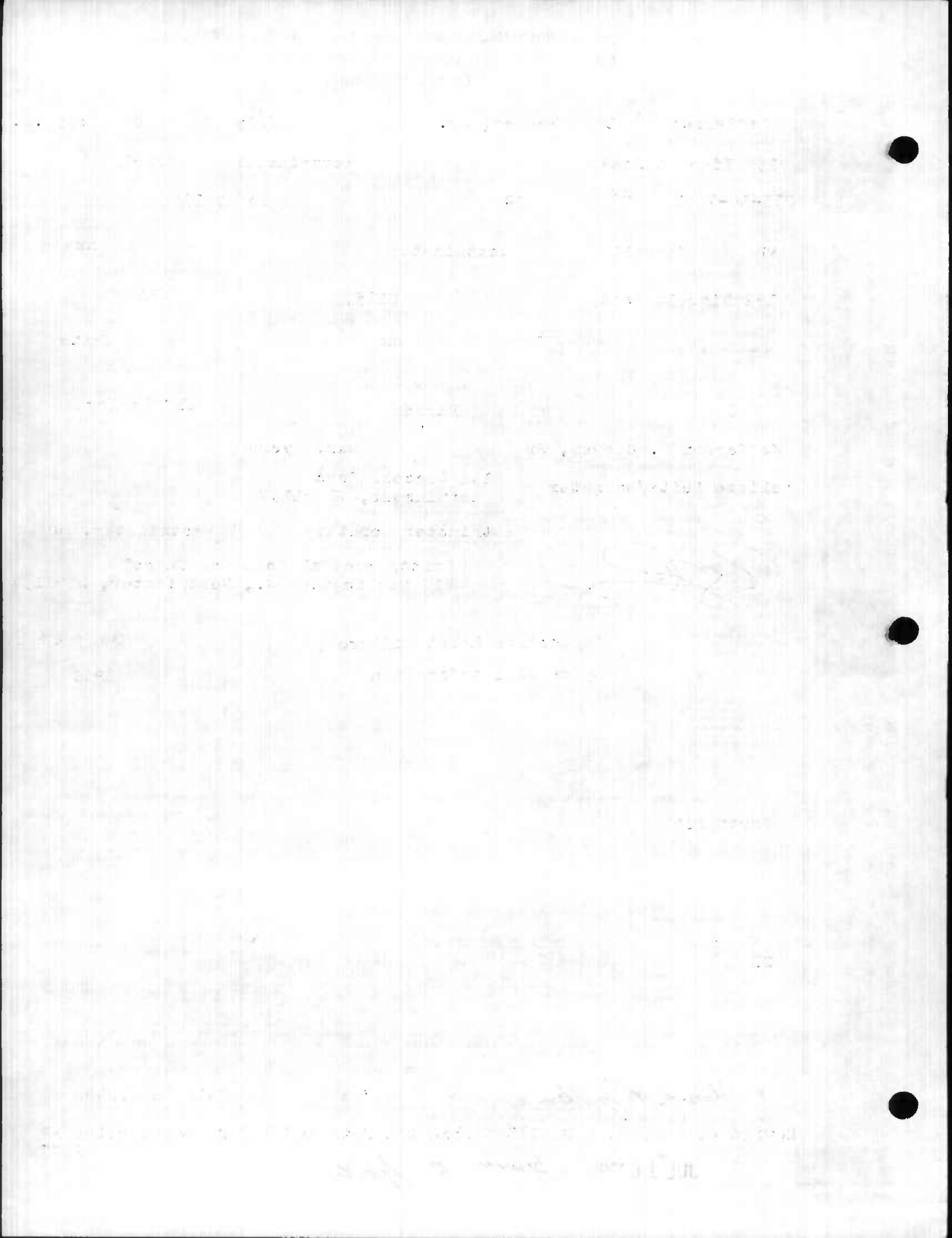
Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24062

| | | | | | | | | |
|--|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARTHA HARRISON | | | | 2. Date of Death Month Day Year JULY 19, 1999 | | 3. Time of Death 10:30 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 219 10 5149 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) April 26, 1913 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Lusby | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 9710 H.G. Trueman Road | | 10f. Zip Code 20657 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse | | 16b. Kind of Business/Industry Health Care | | | |
| | 17. Father's Name (First, Middle, Last) Walter Scott Dayley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Abby V. Wolfe | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Blanche A. Milling- rep personal | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 24 Lusby Maryland 20657 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Harmony Cemetery | | 20c. Location - City or Town, State Owings Cal Maryland | | 20d. Date of Disposition July 21, 1999 | |
| | 21. Signature of Funeral Service Licensee B. Rausch | | | | 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20678 | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CONGESTIVE HEART FAILURE | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death und | | | | | | | |
| | Physician /Medical Examiner | 23c. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE | | | | | | |
| 23d. Due to (or as a consequence of): | | | | | | | | |
| 23e. Due to (or as a consequence of): | | | | | | | | |
| 23f. Due to (or as a consequence of): | | | | | | | | |
| 23g. Due to (or as a consequence of): | | | | | | | | |
| 23h. Due to (or as a consequence of): | | | | | | | | |
| 23i. Due to (or as a consequence of): | | | | | | | | |
| 23j. Due to (or as a consequence of): | | | | | | | | |
| 23k. Due to (or as a consequence of): | | | | | | | | |
| 23l. Due to (or as a consequence of): | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. UROSEPSIS, LEUKEMOID REACTION, DM, HTN CHRONIC RENAL FAILURE, ACUTE TUBULAR NECROSIS ILEUS, HYPOTHYROIDISM, DEMENTIA DIVERTICULAR DISEASE, COLOSTOMY | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier Fulton Lukban | | 29c. License number D50963 | | 29d. Date signed (Month, Day, Year) 7/19/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Fulton Lukban, M.D. Prince Frederick, MD. 20678 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 21 1999 | | 32. Registrar's Signature B. Spauld | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24063

| | | | | | |
|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELEANOR HILLENBRAND | | 2. Date of Death Month JULY Day 14 Year 1999 | | 3. Time of Death 11:00 am |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert |
| Funeral Director | 5. Social Security Number 090 10 5211 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) NOV 27 1912 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State Maryland | 10b. County Calvert | 10c. City, Town or Location Solomons | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 11450 Asbury Circle # 308 | | 10f. Zip Code 20688 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | 16b. Kind of Business/Industry own home |
| | 17. Father's Name (First, Middle, Last) Arthur E. Wilshaw | | 18. Mother's Name (First, Middle, Maiden Surname) Ella M. Metzgar | | |
| | 19a. Informant's Name/Relationship (Type, Print) Joan Hogenson- daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 504 Solomons Maryland 20688 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Location - City or Town, State July 20 1999 Philadelphia Pennsylvania |
| | 21. Signature of Funeral Service Licensee B. Rausch | | 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic Maryland 20676 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diverticulitis | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Dr. Paul Pomilla | | 29c. License number 046314 | | 29d. Date signed (Month, Day, Year) 7/14/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Paul Pomilla, M.D., Prince Frederick, Maryland 20678 | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24064

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Nancy Hillock | | | | | | 2. Date of Death Month Day Year July 13, 1999 | | 3. Time of Death 1:10PM | | |
| | 4a. Facility Name (If not institution, give street and number) Bayside Care Center | | | | | | 4b. City, Town, or Location of Death Lexington Park | | 4c. County of Death St. Mary's | | |
| Funeral Director | 5. Social Security Number 577-24-0877 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) December 7, 1922 | | 9. Birthplace (State or Foreign Country) Bartonsville, VA | | |
| | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County St. Mary's | | 10c. City, Town or Location Lexington Park | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 21064 Arizona Lane | | 10f. Zip Code 20653 | | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dental Assistant | | 16b. Kind of Business/Industry Dentistry | | 17. Father's Name (First, Middle, Last) E. Clark Shenk | | 18. Mother's Name (First, Middle, Maiden Surname) Lois Hottel | | 19. Informant's Name/Relationship (Type, Print) Jeffrey Haymes | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Location - City or Town, State Beltsville Maryland | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Sterling Funeral Service 1601 Kenilworth Avenue, Washington, D.C. 20019 | | 23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cardio pulmonary Failure Due to (or as a consequence of): b. Carcinomatosis Due to (or as a consequence of): c. Cancer of Lung Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 days 6 mo. 2 yrs. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No NA | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D 06419 | | 29d. Date signed (Month, Day, Year) 7-14-99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, M.D. 25035 Three Notch Road, Hollywood, Maryland 20636 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24065

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Katherine Lee ISEMINGER

2. Date of Death

July 11, 1999

Day Year

3. Time of Death

0925

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-52-1458

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 16, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Funkstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9 Frederick Road

10f. Zip Code

21734

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

her own home

17. Father's Name (First, Middle, Last)

Carl Lee Moats

18. Mother's Name (First, Middle, Maiden Summa)

Lola K. Showe

19a. Informant's Name/Relationship (Type, Print)

Judith Gossard - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 892, Funkstown, Maryland 21734

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Funkstown Cemetery

Date

7-14-99

20c. Location - City or Town, State

Funkstown, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

MINNICH FUNERAL HOME
415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D21457

29d. Date signed (Month, Day, Year)

7-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Waheed 12821 Oak Hill Ave. Hager. Md. 21742

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24066

| | | | | | | | | | | | |
|--|---|------------------------|--|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Emma Louise Johnston | | | | 2. Date of Death Month Day Year July 16 1999 | | | | 3. Time of Death 1:35AM | | |
| | 4a. Facility Name (If not institution, give street and number) 1107 Washington Rd. | | | | 4b. City, Town, or Location of Death Westminster | | | | 4c. County of Death Carroll | | |
| Funeral Director | 5. Social Security Number 219-12-1822 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 5, 1917 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Westminster | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 542 Old Westminster Pike | | | | 10f. Zip Code 21157 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) seamstress | | | 16b. Kind of Business/Industry sewing factory | | | | |
| 17. Father's Name (First, Middle, Last) William G. Rumbold | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Louise Ermer | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jeanne Bass/ daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Washington Rd. Westminster, MD 21157 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Westminster Cemetery | | Data 7/19/99 | | 20c. Location - City or Town, State Westminster, MD | | | | |
| 21. Signature of Funeral Service Licensee Catharine D. Hartzler | | | | | 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RENAL CA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 1 1/2 mo | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) daughter's residence | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier Flavio Kruter MD | | 29c. License number D35 398 | | 29d. Date signed (Month, Day, Year) 7-16-99 | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Flavio Kruter, MD 224 Washington Heights Westminster, MD 21157 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 19 1999 | | | | | 32. Registrar's Signature Geneva B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]


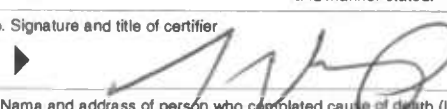

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24067

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|---|--|---|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN JOHNSON | | | | 2. Date of Death Month JULY Day 13 Year 1999 | | | | 3. Time of Death 18:42 | | | |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | | | 4b. City, Town, or Location of Death Prince Frederick | | | | 4c. County of Death Calvert | | | |
| Funeral Director | 5. Social Security Number 214-36-3340 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 61 Yrs. | | 8. Date of Birth Month Jan. Day 17 Year 1938 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Calvert | | 10c. City, Town or Location Port Republic | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 3095 Hance Road | | | | 10f. Zip Code 20676 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | | 16b. Kind of Business/Industry Construction | | | |
| | 17. Father's Name (First, Middle, Last) John Johnson, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ernestine Gray | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Shelly Gray/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Ave. C St. Leonard, MD 20685 | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ernestine Jones Cemetery | | | | Date 7/17/99 | | 20c. Location - City or Town, State Chesapeake Beach, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease Laryngeal Cancer | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier  | | | | 29c. License number 033123 | | | | 29d. Date signed (Month, Day, Year) 7-14-99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN D LOWENTHAL, M.D. Prince Frederick, Maryland 20678 | | | | | | | | | | | |
| State Registrar | 31. Data filed (Month, Day, Year) JUL 16 1999 | | | | 32. Registrar's Signature  | | | | | | | |
| | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | |
|--|--|---|--|---|--------------------------------|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) JACK VERDEAN LITTLE, SR | | | | | | 2. Date of Death Month JULY Day 9 Year 1999 | | 3. Time of Death 0845 | |
| 4a. Facility Name (If not institution, give street and number) 305 ROCKDALE ST | | | | | | 4b. City, Town, or Location of Death FREDERICK | | 4c. County of Death FREDERICK | |
| 5. Social Security Number 177-24-2903 | | 6. Sex 1 M 2 F | 7. Age (in yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) OCT 15, 1930 | | 9. Birthplace (State or Foreign Country) WAYNESBORO, PA | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State PA | | 10b. County FRANKLIN | | 10c. City, Town or Location WAYNESBORO | | | | 10d. Inside City Limits 1 Yes 2 No | |
| 10e. Street and Number 11850 ORCHARD LANE | | | | 10f. Zip Code 17268 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1953 TO 1955 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (9-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DIRECTOR OF SALES | | | 16b. Kind of Business/Industry MACHINE COMPANY | | |
| 17. Father's Name (First, Middle, Last) ALSON S. LITTLE | | | | 18. Mother's Name (First, Middle, Maiden Surname) M. GRACE SNYDER | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) LAURIE K. WRIGHT | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 ROCKDALE ST FREDERICK PA 21702 | | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) QUINCY CEMETERY | | Date 7/12 | | 20c. Location - City or Town, State QUINCY PA 17247 | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Grove Funeral Home, Inc. 50 S Broad ST Waynesboro PA 17268 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Prostate Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 1 yr | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? 1 Yes 2 No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) daughter's home | | | | | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | | | 29c. License number D 41866 | | 29d. Date signed (Month, Day, Year) July 9, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Hudhud, MD 801 Tollhouse Avenue, D3 Frederick, MD 21701 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 12 1999 | | 32. Registrar's Signature  | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24069

| | | | | | | | | | |
|--|---|---|--------------------------------------|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James William League | | | | 2. Date of Death Month Day Year July 7, 1999 | | 3. Time of Death 1210 A.M. | | |
| | 4e. Facility Name (If not institution, give street and number) Homewood Nursing Home | | | | 4b. City, Town, or Location of Death Williamsport | | 4c. County of Death Washington | | |
| Funeral Director | 5. Social Security Number 220-03-3036 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 9, 1916 | 9. Birthplace (State or Foreign Country) WVa. | | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State Md. | | 10b. County Washington | | 10c. City, Town or Location Williamsport | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 16505 Virginia Ave. | | | | 10f. Zip Code 21795 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | 16b. Kind of Business/Industry Retail | | | |
| 17. Father's Name (First, Middle, Last) William Henry League | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cecelia Cockrell League | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) John W. League son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10733 Hershey Dr. Williamsport, Md. 21795 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Edge Hill Cemetery | | Date 7/9/1999 | | 20c. Location - City or Town, State Charles Town, WVa. | | | |
| 21. Signature of Funeral Service Licensee <i>Carol C. Burner</i> | | | | 22. Name and Address of Facility Burner Trade Services 1037 Dual Pl. Hagerstown, Md. 21740 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <i>Acute Myocardial Infarction</i> Due to (or as a consequence of): b. <i>Atherosclerosis</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death <i>Unknown</i> <i>Days</i> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Artrial Fibrillation</i> <i>Hypertension</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Heidi Duncan</i> | | 29c. License number 17067 | | 29d. Date signed (Month, Day, Year) 7/7/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Stephan E. Weirich, MD 747 Northern Ave. Hagerstown, Md</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 08 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | |

To Be Completed by Funeral Director

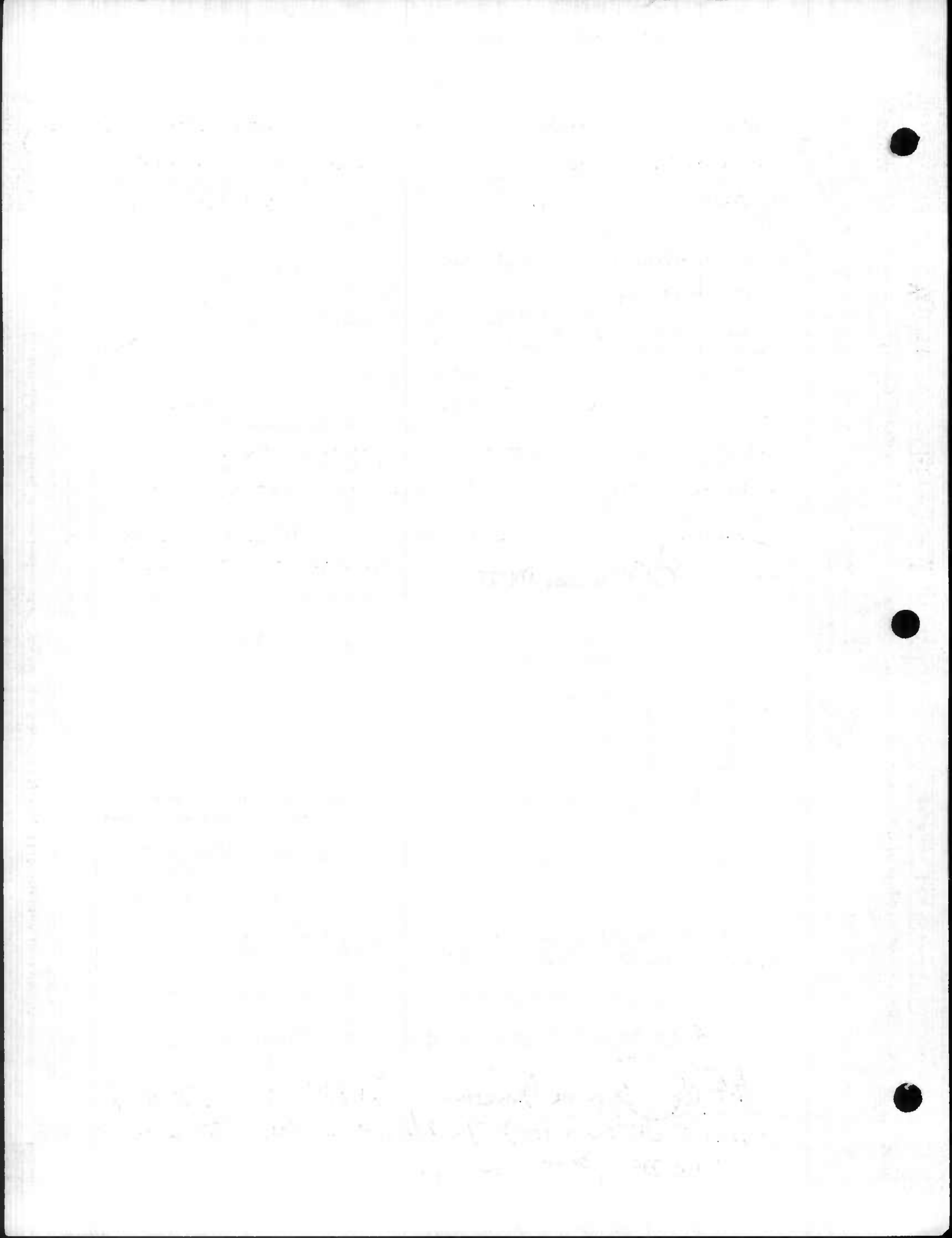
Medical Certification: To Be Completed by Physician/Medical Examiner

7-7-99 1210A
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

James League
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24070

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BELVA MAE LITTLETON

2. Date of Death

Month
JULYDay
20,Year
1999

3. Time of Death

11:10 P.M.

4a. Facility Name (If not institution, give street and number)

Berlin Nursing and Rehabilitation Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

218-80-3927

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

8/23/14

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8257 Bethards RD

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

James D. Bethards

18. Mother's Name (First, Middle, Maiden Surname)

Chloe Timmons

19a. Informant's Name/Relationship (Type, Print)

Katherine M. Littleton/ Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8206 Bethards RD Berlin, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverside Cemetery

Date

7/23/99

20c. Location - City or Town, State

Libertytown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burbage Funeral Home

108 William St. Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic colon cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

046257

29d. Date signed (Month, Day, Year)

7/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 9714 Heathway Drive Berlin, MD 21811

State
Registrar

31. Date filed (Month, Day, Year)

JUL 22 1999

32. Registrar's Signature

LITTLETON, BELVA

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

[Faint handwritten signature]

[Faint handwritten text] JUL 8 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24071

moning, Gary Albert

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Gary Albert Moning | | 2. Date of Death Month Day Year July 15 1999 | | 3. Time of Death 10:45 Am | |
| 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington County |
| 5. Social Security Number 282-24-0461 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | 8. Date of Birth (Month, Day, Year) Sept. 27, 1929 | 9. Birthplace (State or Foreign Country) Ohio | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Washington Co. | 10c. City, Town or Location Hagerstown | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 1060 Fairview Road | | 10f. Zip Code 21742 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1952-1954 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Stress Engineer | | 16b. Kind of Business/Industry Crane Manufacturing | | | |
| 17. Father's Name (First, Middle, Last) Henry Albert Moning | | | 18. Mother's Name (First, Middle, Maiden Surname) Laura Eleanor Carlson | | |
| 19a. Informant's Name/Relationship (Type, Print) Henry Clarke Moning/Brother | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13407 Keener Road, Hagerstown, Maryland 21742 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | 20c. Location - City or Town, State Jul. 19 Hagerstown, Maryland | |
| 21. Signature of Funeral Service Licensee ► Kelley A. Zimmerman | | 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Basal Ganglia Stroke Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death 4 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Stroke, Hypertension | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier ► Samuel Chaw, MD | | 29c. License number D36655 | | 29d. Date signed (Month, Day, Year) July 15, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1185 Mt. Aetna Rd Hagerstown, MD 21740 | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24072

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SCOTT McCORKLE MITCHELL SR. | | | | 2. Date of Death Month: JULY Day: 14 Year: 1999 | | 3. Time of Death 2010 | |
| | 4a. Facility Name (If not Institution, give street and number) WASHINGTON COUNTY HOSPITAL | | | | 4b. City, Town, or Location of Death HAGERSTOWN | | 4c. County of Death WASHINGTON | |
| Funeral Director | 5. Social Security Number 410-24-1851 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 14, 1920 | |
| | 9. Birthplace (State or Foreign Country) TENNESSEE | | 10a. State MARYLAND | | 10b. County WASHINGTON | | 10c. City, Town or Location ROHRERSVILLE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 3701 CLEAR RUN PLACE | | 10f. Zip Code 21779 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1952 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER | | 16b. Kind of Business/Industry ELECTRONICS MANUF. | | 17. Father's Name (First, Middle, Last) WILL POINDEXTER MITCHELL | |
| | 18. Mother's Name (First, Middle, Maiden Surname) NELL RUTH McCORKLE | | 19a. Informant's Name/Relationship (Type, Print) ANN S. MITCHELL/SPOUSE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 CLEAR RUN PLACE, ROHRERSVILLE, MARYLAND 21779 | | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) SMITHSBURG CREMATORY | | 20c. Date 7/15/99 | | 20d. Location - City or Town, State SMITHSBURG, MARYLAND | | 21. Signature of Funeral Service Licensed Paul M. Dean | |
| | 22. Name and Address of Facility BAST FUNERAL HOME Boonsboro, Maryland 21713 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 2 days | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier Michael J. McCormick MD | | 29c. License number 041667 | | 29d. Date signed (Month, Day, Year) 7-15-99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. McCormick 11110 Medical Campus Rd. Hagerstown MD 21742 | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 16 1999 | | 32. Registrar's Signature B. Sparks | | 33. Date of Death (Month, Day, Year) JUL 14 1999 | | 34. Time of Death (Hour, Minute) 2010 | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24073

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|---------------------------|---|--|--|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ruth Louise MOSER | | | | 2. Date of Death Month Day Year July 11, 1999 | | | | 3. Time of Death 2151 | | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | | | 4c. County of Death Washington | | |
| Funeral Director | 5. Social Security Number 214-09-4628 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) July 8, 1911 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 1158 Luther Drive | | | | 10f. Zip Code 21740 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) + | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) secretary | | | | 16b. Kind of Business/Industry city government | | | |
| 17. Father's Name (First, Middle, Last) Frank D. Hollyday | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Clara E. Leatherman | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Richard Helfrich - nephew | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 347 Pangborn Blvd., Hagerstown, Md. 21740 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | Date 7-15-99 | | 20c. Location - City or Town, State Hagerstown, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute myocardial Infarction Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death 4 hrs. Unknown | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma of breast Pulmonary Fibrosis | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D 46561 | | 29d. Date signed (Month, Day, Year) 7-14-99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Padin 20311 Lappan Rd. Boonsboro, Md. | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

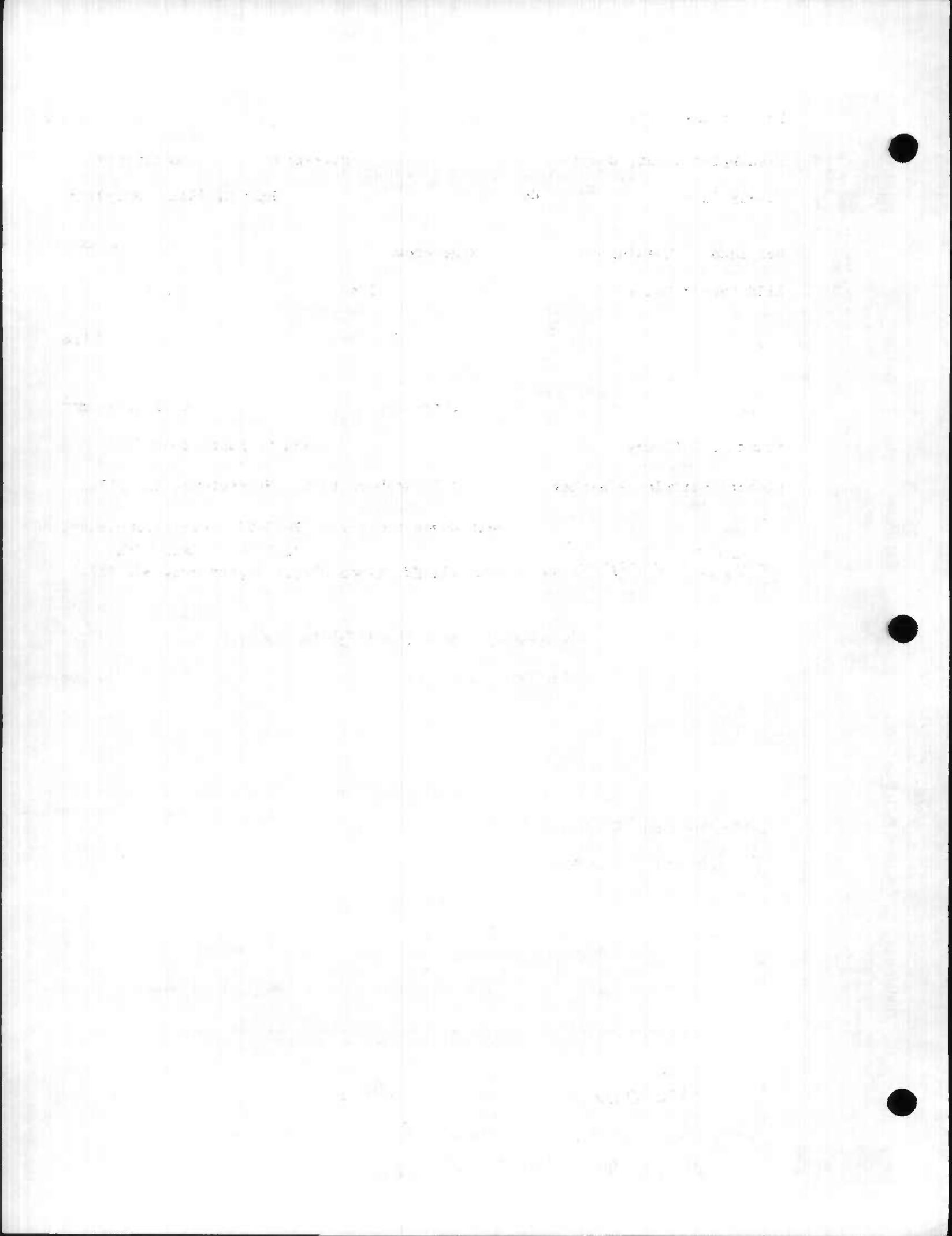
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be ascertained within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24074

| | | | | | |
|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANK MARMA DUKE | | 2. Date of Death Month 7 Day 11 Year 1999 | | 3. Time of Death 4:25 PM |
| | 4a. Facility Name (If not institution, give street and number) WESTERN MD Hospital Center | | 4b. City, Town, or Location of Death HAGERSTOWN | | 4c. County of Death WASHINGTON |
| Funeral Director | 5. Social Security Number 214-34-0494 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 62 Yrs. | If Under 1 Year Months 0 Days 0 | If Under 24 Hrs. Hours 0 Min. 0 |
| | 8. Date of Birth (Month, Day, Year) Feb. 4, 1937 | | 9. Birthplace (State or Foreign) Maryland | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Md. | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 621 W. Franklin St. | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter | | 16b. Kind of Business/Industry Homes | |
| 17. Father's Name (First, Middle, Last) William B. Marmaduke | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret A. Slick | | | |
| 19a. Informant's Name/Relationship (Type, Print) Tammy Heare (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307 Potomac Ave. Hagerstown, Md. 21742 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory | | 20c. Location - City or Town, State July 13, 1999 Smithsburg, Md. | |
| 21. Signature of Funeral Service Licensee Dennis L. Davis | | 22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | Approximate Interval Between Onset and Death 41 days | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Due to (or as a consequence of): Cardiopulmonary Arrest pneumonia | | | |
| | | Due to (or as a consequence of): | | | |
| | | Due to (or as a consequence of): | | | |
| | | Due to (or as a consequence of): | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| ① Cerebrovascular Accident & Seizure Disor ② Diabetes type II ③ Hypertension | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Francisco L. Andrade | | 29c. License number 027898 | | 29d. Date signed (Month, Day, Year) 7/11/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FRANCISCO L. ANDRADE 350 MILL ST. HAGERSTOWN MD 21740 | | | | | |
| 31. Date filed (Month, Day, Year) JUL 13 1999 | | 32. Registrar's Signature B. Sparks | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. The text is mostly centered and spans most of the page width.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24075

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Glenda Kay Mumma

2. Date of Death

Month Day Year
July 15 1999

3. Time of Death

8:35 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Western Maryland Hospital Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

198-34-6929

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 28 1947

9. Birthplace (State or Foreign Country)

Waynesboro

Usual Residence of Decedent

10a. State

PA

10b. County

Franklin

10c. City, Town or Location

Waynesboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

345 Antietam Dr.

10f. Zip Code

17268

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Shipping/Delivery Company

17. Father's Name (First, Middle, Last)

J. Paul Whitlock

18. Mother's Name (First, Middle, Maiden Surname)

Alberta J. Bricker

19a. Informant's Name/Relationship (Type, Print)

Eric C. Mumma

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14969 Ridge Rd. Waynesboro PA 17268

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cumberland Valley Crematorium

Date

July 16
1999

20c. Location - City or Town, State

Waynesboro PA

21. Signature of Funeral Service Licensee

James L. Bowersox

22. Name and Address of Facility

Grove Funeral Home 50 S. Broad St. Waynesboro
PA 1726823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Electrolyte imbalance

Due to (or as a consequence of):

b. End Stage Renal Disease

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Ian H. Newbold

29c. License number

D41112

29d. Date signed (Month, Day, Year)

July 15 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ian H. Newbold 1500 Pennsylvania Ave. Hagerstown MD 21740

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

James L. Bowersox

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Received of Mr. C. H. [illegible]

July 21

James H. [illegible]

July 21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended line 5.

State of Maryland / Department of Health and Mental Hygiene

99 24076

WCHD SC 7-14-99

Certificate of Death

Reg. No.

Physician
(Medical
Examiner)Funeral
Director

| | | | | | |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Edward Joseph MILLER | | 2. Date of Death Month: July Day: 9 Year: 1999 | | 3. Time of Death 5:25 | |
| 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| 5. Social Security Number 214-26-13071304 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | 8. Date of Birth (Month, Day, Year) Sept. 26, 1929 | 9. Birthplace (State or Foreign Country) Maryland | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Washington | 10c. City, Town or Location Hagerstown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 17817 Red Oak Drive | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-1949 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 0-12 College (1-4or 5+): 2 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) engineer | | 16b. Kind of Business/Industry state highway adminis | | | |
| 17. Father's Name (First, Middle, Last) Raymond M. Miller | | 18. Mother's Name (First, Middle, Maiden Surname) Theresa M. Dettmer | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Ruth Miller/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17817 Red Oak Drive, Hagerstown, Maryland 21740 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park | | 20c. Location - City or Town, State Hagerstown, Maryland | |
| 21. Signature of Funeral Service Licensee Fred L. [Signature] | | 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute Cardiac Arrest Due to (or as a consequence of): f. Acute M.I. Due to (or as a consequence of): g. Coronary Atherosclerosis Due to (or as a consequence of): h. Cardiac Myopathy | | | | | Approximate Interval Between Onset and Death Immediate 1 hour yrs. yrs. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number 217029 | | 29d. Date signed (Month, Day, Year) July 9, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wm. R. K... 12516 Vac Ave, Hagerstown, Md 21740 | | | | | |
| 31. Date filed (Month, Day, Year) JUL 13 1999 | | 32. Registrar's Signature [Signature] | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
(Medical
Examiner)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

2111

2000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24077
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|--|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen Irene MYERS | | | | 2. Date of Death Month Day Year JULY 8, 1999 | | | | 3. Time of Death 3:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) RAVENWOOD LUTHERAN VILLAGE | | | | 4b. City, Town, or Location of Death HAGERSTOWN | | | | 4c. County of Death WASHINGTON | |
| Funeral Director | 5. Social Security Number 220-48-3101 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) March 10 1905 | | 9. Birthplace (State or Foreign Country) West Virginia | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 448 East First Street | | | | 10f. Zip Code 21740 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Founder | | | | 16b. Kind of Business/Industry Block Company | | | | 17. Father's Name (First, Middle, Last) Josephus Marshall | |
| | 18. Mother's Name (First, Middle, Maiden Surname) May Baker | | | | 19a. Informant's Name/Relationship (Type, Print) Vernon Myers - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1155 The Terrace Hagerstown, Md. 21742 | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery | | | | 20c. Location - City or Town, State 7/12/99 Hagerstown, Maryland | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE PULMONARY EDEMA Due to (or as a consequence of): b. CHRONIC CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D07857 | | | | 29d. Date signed (Month, Day, Year) JULY 8, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDSON MOODY M.D., 1190 MT.AETNA ROAD, HAGERSTOWN, MD 21740 | | | | 31. Date filed (Month, Day, Year) JUL 14 1999 | | | | 32. Registrar's Signature  | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24078

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Barbara Marie Martin | | | | 2. Date of Death Month Day Year JULY 01 1999 | | 3. Time of Death 0049 | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 131-28-6073 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 61 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 4, 1938 | |
| | 9. Birthplace (State or Foreign Country) NY | | 10a. State MD | | 10b. County Washington | | 10c. City, Town or Location Clear Spring | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 12013 National Pike | | 10f. Zip Code 21722 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| To Be Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) clerk, service manager | | 16b. Kind of Business/Industry Food Market | | | |
| | 17. Father's Name (First, Middle, Last) Vincent L. Talbot | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Dyanick | | | |
| To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (Type, Print) Courtney Martin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12013 National Pike Clear Spring, MD. 21722 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cem. July 10, 1999 | | 20c. Location - City or Town, State Clear Spring, MD | | 21. Signature of Funeral Service Director <i>[Signature]</i> | |
| Physician /Medical Examiner | 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc PO BOX 310 Clear Spring, MD 21722 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiovascular arrest Due to (or as a consequence of): acute myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last coronary artery disease Due to (or as a consequence of): 12 years | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) NA | | 28b. Time of Injury NA | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred NA | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NA | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) NA | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>[Signature]</i> F. Pura | | 29c. License number D 19824 | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) July 7, 1999 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GLORIA F. PURA 366 Mill St. Hagerstown, MD 21740 | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 08 1999 | | 32. Registrar's Signature <i>[Signature]</i> B. Sparks | | | | | |

611

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24079

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARIE EVELYN MARTIN

2. Date of Death

July 17 1999

Day Year

3. Time of Death

3:05 AM

4a. Facility Name (If not institution, give street and number)

Carroll Lutheran Village Health Care

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

213-09-5446

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 8, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

300 St. Luke Circle

10f. Zip Code

21158

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Nurses Aide

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Luther Cleveland Martin

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Jane Berwager

19a. Informant's Name/Relationship (Type, Print)

Elaine Ruby/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1609 Fairmount Rd. Hampstead, MD 21074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. John's Lutheran 7/19/99

Date

20c. Location - City or Town, State

Westminster, MD

21. Signature of Funeral Service Licensee

Jennifer L. Schen

22. Name and Address of Facility

91 Willis Street
Myers Funeral Home Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMER'S DEMENTIA

Approximate Interval Between Onset and Death

10 years

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard G. Lanham

29c. License number

D17040

29d. Date signed (Month, Day, Year)

July 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard G. Lanham, M.D. 215 Washington Hgts Med'l Ctr, Westminster, MD

State
Registrar

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

Jennifer L. Schen

21157

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24080

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Braden Douglas Mann | | | | 2. Date of Death Month Day Year JULY 14, 1999 | | | | 3. Time of Death 0025 AM | |
| | 4a. Facility Name (If not institution, give street and number) ROUTE#27 @ EAST RIDGEVILLE | | | | 4b. City, Town, or Location of Death MT. AIRY | | | | 4c. County of Death CARROLL | |
| Funeral Director | 5. Social Security Number 190-64-6938 | | 8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 18 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Westminster | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 2324 Beren Lane | | | | 10f. Zip Code 21157 | | | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | | | | 16b. Kind of Business/Industry NA | |
| | 17. Father's Name (First, Middle, Last) Gregory L. Mann | | | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara S. Johnson | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Gregory Mann (Father) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2324 Beren Lane Westminster, MD 21157 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crown Crest Memorial Park | | | | 20c. Location - City or Town, State 7/19/99 Clearfield, PA | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Burrier-Queen Funeral Directors, PA 1212 W. Old Liberty Rd. Winfield, MD 21784 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24e. Was an autopsy performed? Inspection 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) 7/14/99 | | | | 28b. Time of Injury 0011 M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred Passenger in vehicle struck by truck 28f. Location (Street and Number or Rural Route Number, City or Town, State) Mount Airy, Maryland | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street Rt. 27 | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier J. Pestaner, MD | | | | 29c. License number O.C.M.E | | |
| 29d. Date signed (Month, Day, Year) JULY 14, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | |

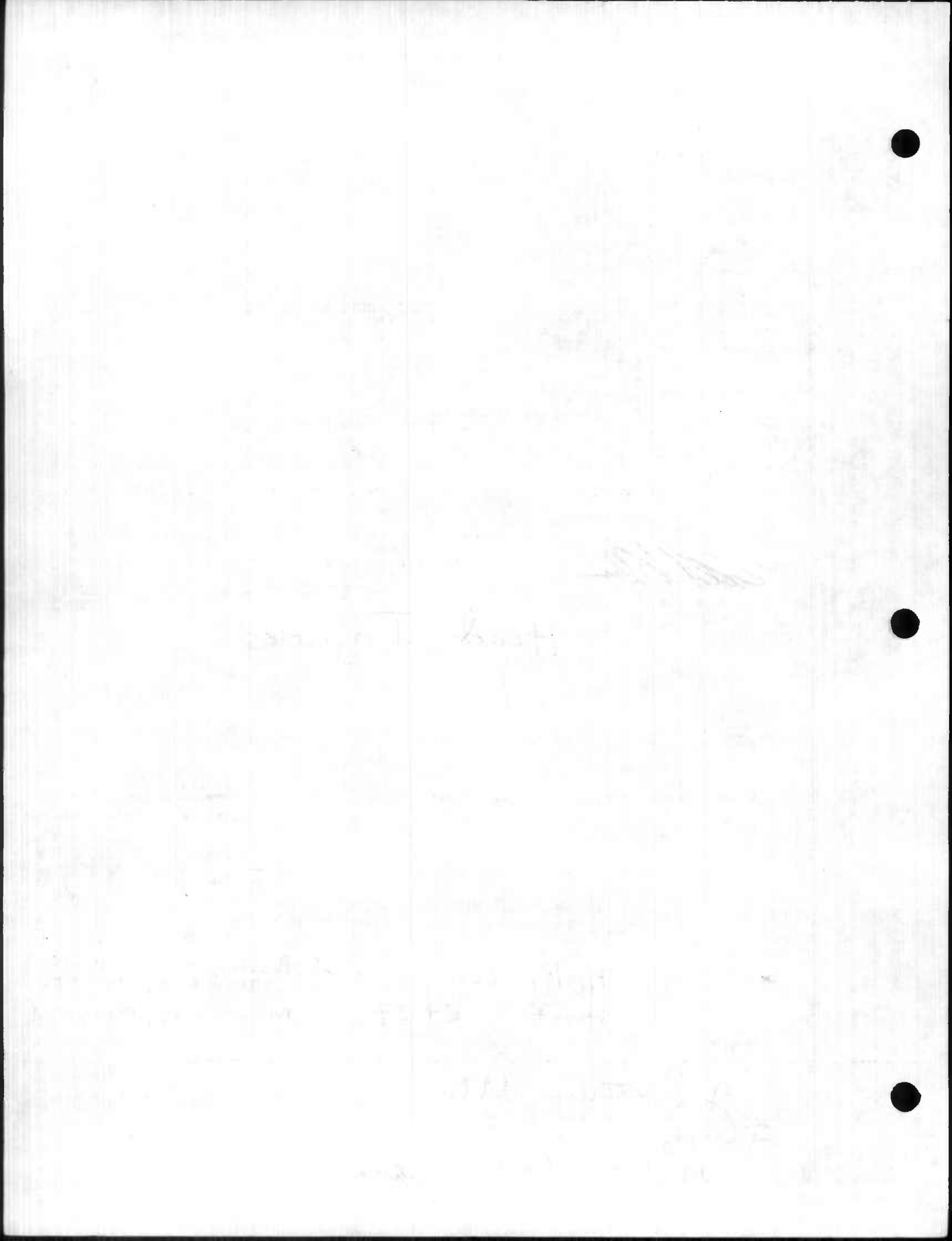
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24081

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CORA MAE NETHERTON

2. Date of Death

Month
JULYDay
17Year
1999

3. Time of Death

3:30 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SOLOMONS NURSING CENTER

4b. City, Town, or Location of Death

SOLOMONS

4c. County of Death

CALVERT

5. Social Security Number

577 18 3827

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 30, 1918

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5914 Old Croom Station Road

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Walker

18. Mother's Name (First, Middle, Maiden Surname)

Elleanor Minder

19a. Informant's Name/Relationship (Type, Print)

John Netherton (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5918 Old Croom Station Road, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

July 20, 1999

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Kelli R. Patten

22. Name and Address of Facility

LEE FUNERAL HOME, INC.

6633 OLD ALEXANDER FERRY RD. CLINTON, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OBS, MALNUTRITION, CHRONIC RENAL FAILURE,

CONGESTIVE HEART FAILURE, CORONARY ARTERY DISEASE,

HTN, CAS, HYPOTHYROIDISM, MR, PVD, BKA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Fulton P. Lukban

29c. License number

D50963

29d. Date signed (Month, Day, Year)

JULY 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FULTON P. LUKBAN, M.D. 135 W. DARES BEACH RD. SUITE 109 PRINCE FREDERICK, MD 20678

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24082

WILLIAM
NAUGHTONPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Kenneth Naughton

2. Date of Death

JULY 8, 1999

3. Time of Death

2:54A.M.

4a. Facility Name (If not institution, give street and number)

CALVERT MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

PRINCE FREDERICK

4c. County of Death

CALVERT

Funeral
Director

5. Social Security Number

212 66 6407

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 26 1954

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State
Maryland10b. County
Calvert10c. City, Town or Location
Lusby

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

954 Crystal Rock Road

10f. Zip Code

20657

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Retail Clerk

16b. Kind of Business/Industry

Safeway

17. Father's Name (First, Middle, Last)

William T. Naughton

18. Mother's Name (First, Middle, Maiden Surname)

Shirley J. Doss

19a. Informant's Name/Relationship (Type, Print)

Sandra L. Naughton- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

967 Laredo Trail Lusby, MD 20657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Southern Memorial Gardens July 10, 1999

20c. Location - City or Town, State

Dunkirk Maryland

21. Signature of Funeral Service Licensee

B Rausch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broomes Is. Rd. Port Republic MD 20670

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?
INSPECTION1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Theodore M. King M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 9, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore King M.D.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24083

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Roy Lee Orndorff, Sr.

2. Date of Death

Month
JulyDay
20Year
1999

3. Time of Death

3:45 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Homewood Retirement Center

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

5. Social Security Number

718-18-7821

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year
July 26, 1904

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16505 Virginia Avenue Cottage #214

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Director

16b. Kind of Business/Industry

Sanitation Commission

17. Father's Name (First, Middle, Last)

Joseph William Orndorff

18. Mother's Name (First, Middle, Maiden Summa)

Laura Lee Snyder

19a. Informant's Name/Relationship (Type, Print)

John Orndorff/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

51 Shadow Wood Way Ballston Lake, New York 12019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenhill Cemetery

Data

7-23-99

20c. Location - City or Town, State

Buena Vista, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home

425 S. Conococheague St. Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Arteriosclerotic cardiovascular disease

a. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fractured hip. Deventia
Parkinson disease
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicida 4 ☐ Homicida28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D26601

29d. Date signed (Month, Day, Year)

7/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aunt Joan 745 Notion Ave Hyattsville MD 21242

31. Date filed (Month, Day, Year)

JUL 22 1999

32. Registrar's Signature

State
Registrar

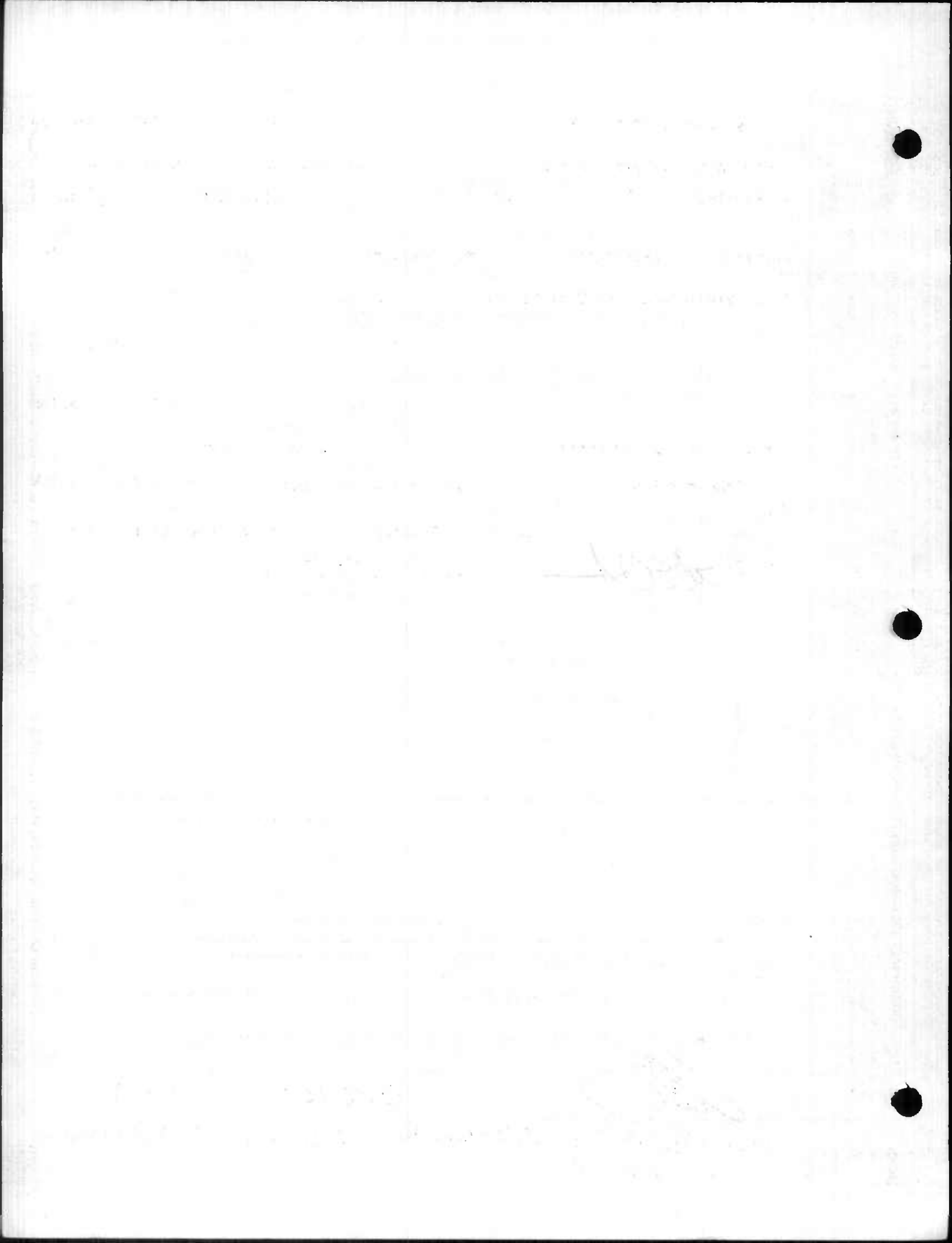
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



WRC
99-4271-043
WILLIAM R.
PALMER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

99 24084

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) William Richard PALMER | | 2. Date of Death Month Day Year JULY 20, 1999 | | 3. Time of Death 10:24 AM. | |
| 4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL | | 4b. City, Town, or Location of Death HAGERSTOWN | | 4c. County of Death Washington | |
| 5. Social Security Number 220-58-3143 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 4 1952 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 16124 Broadfording Road | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Delivery Person | | 16b. Kind of Business/Industry Donut Shop | |
| 17. Father's Name (First, Middle, Last) Luther David Palmer | | 18. Mother's Name (First, Middle, Maiden Surname) Lola May Reickard | | | |
| 19a. Informant's Name/Relationship (Type, Print) Patsy Ann Palmer - Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16124 Broadfording Road Hagerstown, Md. 21740 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | 20c. Location - City or Town, State 7/23/99 Hagerstown, Maryland | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 21, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) JUL 22 1999 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24085

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Irene Helen Podwoiski | | | | 2. Date of Death Month Day Year July 14 1999 | | | | 3. Time of Death 1720 | | |
| | 4a. Facility Name (If not institution, give street and number) Montgomery County General Hospital | | | | 4b. City, Town, or Location of Death Olney | | | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 361-44-0014 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) April 28 1917 | | 9. Birthplace (State or Foreign Country) Indiana | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Md | | 10b. County Howard | | 10c. City, Town or Location Mount Airy | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 16241 Compromise Court | | | | 10f. Zip Code 21771 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | | | 16b. Kind of Business/Industry domestic | | | |
| 17. Father's Name (First, Middle, Last) Walter Krueger | | | | 18. Mother's Name (First, Middle, Maiden Surname) Martha Holtz | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marcella Nuenke (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3241 Sharp Rd., Glenwood, Md 21738 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Hill Cemetery | | Date 7-17-99 | | 20c. Location - City or Town, State Hammond, Indiana | | | | | |
| 21. Signature of Funeral Service Licensee Brian D. Haight | | | | 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. <u>Adynamic Ileus</u> Due to (or as a consequence of): b. <u>Methicillin Resistant Staphylococcus Aureus Septicemia</u> Due to (or as a consequence of): c. <u>Enterococcus Septicemia</u> Due to (or as a consequence of): d. | | | | | | | | | | 3 weeks 8 days 10 days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Bennett Morrison MD | | | | 29c. License number D 47682 | | | | 29d. Date signed (Month, Day, Year) July, 14, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bennett Morrison 2901 Olney - Sandy Spring Road, Olney, Maryland, 20832 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 15 1999 | | 32. Registrar's Signature Benita B. Sparks | | | | | | | | | |

To Be Completed by Funeral Director

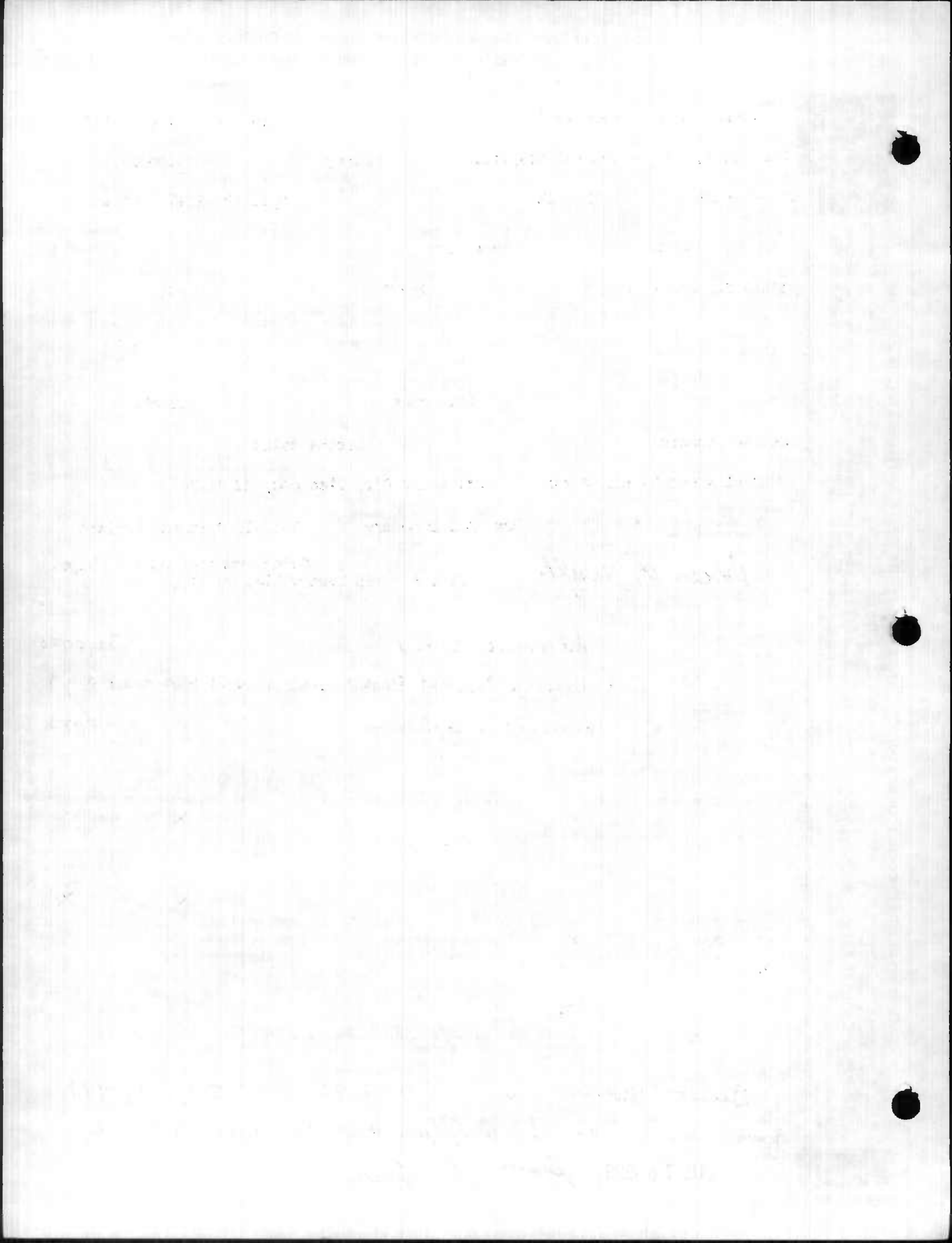
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in advance.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24086

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT JOSEPH PLATT, SR.

2. Date of Death

JULY 20 1999 11:05PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

29756 SKYVIEW

4b. City, Town, or Location of Death

MECHANICSVILLE CHARLES

4c. County of Death

5. Social Security Number

281-42-4940

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 3, 1946

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND ST. MARY'S

10b. County

10c. City, Town or Location

MECHANICSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29756 SKYVIEW DRIVE

10f. Zip Code

20659

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yaa or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YRS. COLLEGE

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

X-RAY TECHNICIAN

16b. Kind of Business/Industry

RADIOLOGY IMAGING

17. Father's Name (First, Middle, Last)

FRANK PLATT

18. Mother's Name (First, Middle, Maiden Surname)

DELORES RILEY

19a. Informant's Name/Relationship (Type, Print)

DORIS PLATT-SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

METROPOLITAN CREMATORY 7-24-99 ALEXANDRIA, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses



22. Name and Address of Facility

RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 2064623a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D28352

29d. Date signed (Month, Day, Year)

JULY 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISHAN MATHUR, MD., P.O. BOX 1703, LA PLATA, MD 20646

31. Date filed (Month, Day, Year)

JUL 22 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24087**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|----------------------------------|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lida Taylor Porter | | | | 2. Date of Death Month: July Day: 14 Year: 1999 | | 3. Time of Death 9:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) Shore Nursing & Rehab Center | | | | 4b. City, Town, or Location of Death Denton | | 4c. County of Death Caroline | |
| Funeral Director | 5. Social Security Number 219-07-2085 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 95 Yrs. | If Under 1 Year Months: Days: | If Under 24 Hrs. Hours: Min. | 8. Date of Birth (Month, Day, Year) Sept 25, 1903 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Caroline | 10c. City, Town or Location Henderson | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 16800 Henderson Rd Lot 88 | | | 10f. Zip Code 21640 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 7 College (1-4 or 5+): | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Processor | | 16b. Kind of Business/Industry Food Processing | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Elijah Taylor | | | | 18. Mother's Name (First, Middle, Maiden Surname) Louise Kemp | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Helen Shewbrooks | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16800 Henderson Rd Lot 84 Henderson, Maryland 21640 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greensboro Cemetery | | Date July 19, 1999 | | 20c. Location - City or Town, State Greensboro, MD | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Fleagle & Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639 | | | | | |
| Physician /Medical Examiner | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10d. Congestive Heart Failure 10d. Coronary Artery Disease | | | | | | | Approximate Interval Between Onset and Death 10d. |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Hypertension | | | | | | | |
| | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Hypertension | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> MD | | | | 29c. License number D35284 | | 29d. Date signed (Month, Day, Year) 7/14/99 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANDREA ALLEN MD 219 S. Washington St Easton MD 21604 | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24088

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---------------------------------|--|--|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) OLLIE ROBERTS | | | | 2. Date of Death Month 7 Day 8 Year 99 | | 3. Time of Death 0700 | |
| | 4a. Facility Name (If not institution, give street and number) 2753 WINCHESTER ST | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death CITY | |
| Funeral Director | 5. Social Security Number 215-16-8377 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 01-31-23 | 9. Birthplace (State or Foreign Country) VIRGINIA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State md | | 10b. County | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 Yes 2 No | |
| 10e. Street and Number 2753 Winchester St | | | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | | 16b. Kind of Business/Industry City of Baltimore | |
| 17. Father's Name (First, Middle, Last) MOSES ROBERTS | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margie ANN STRAND | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Florence DUFFY | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150W 140th ST Apt 2-D New York, NY 10030 | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Household of Ruth | | Date 7/2/99 | | 20c. Location - City or Town, State Accomac, VA | | |
| 21. Signature of Funeral Service Licensee Samuel M. Slaughter | | | | 22. Name and Address of Facility WHARTON FUNERAL HOME 22171 Wharton Rd. Accomac, VA 23301 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Atherosclerosis Due to (or as a consequence of): Diabetes Neuropathy Due to (or as a consequence of): Primary Hypertension Due to (or as a consequence of): ORGANIC Brain Syndrome | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) | | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Robert J. Williams MD | | | | 29c. License number DZ5055 | | 29d. Date signed (Month, Day, Year) 7/16/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 ROBERT J WILLIAMS 5602 BALTIMORE WATERS PK BALTO MD 21228 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 | | | | 32. Registrar's Signature Barbara B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24089

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Edward Rogers

2. Date of Death

Month Day Year
July 12, 1999 2010

3. Time of Death

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

149-42-2060

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 20, 1942

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11885 Kibler Road

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Caucasian15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer/Machinist

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Jack George Rogers

18. Mother's Name (First, Middle, Maiden Surname)

Helen Elizabeth Senis Servis

19a. Informant's Name/Relationship (Type, Print)

Shirley Bacorn Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 East King Street, Seaford, Delaware 19973

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Capitol Crematory

Date

7/13/99

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee

B. Moore

22. Name and Address of Facility

Nps RE Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)a. Obesity hypoventilation syndrome
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

5 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cardiomyopathy
decubitus ulcers

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Peter Whitesell, M.D.

29c. License number

D44749

29d. Date signed (Month, Day, Year)

7/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Whitesell, M.D., 508 Idlewild Avenue, Easton, Maryland 21629

State
Registrar

31. Date filed (Month, Day, Year)

JUL 13 1999

32. Registrar's Signature

B. Sparks

Robert Rogers
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

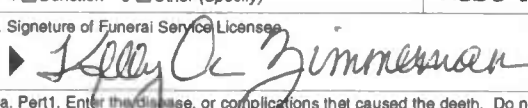
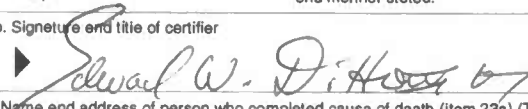
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24090

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE LEE SIEBERT | | | | 2. Date of Death Month July Day 13 Year 1999 | | 3. Time of Death 4:30 am | | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | | |
| Funeral Director | 5. Social Security Number 219-36-3200 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) June 25, 1941 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. Usual Residence of Decedent 10a. State Maryland 10b. County Washington Co. 10c. City, Town or Location Hagerstown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 13634 Ivy Way | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 06/15/59 07/15/65 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer | | 16b. Kind of Business/Industry City | | | | | |
| 17. Father's Name (First, Middle, Last) Arthur L. Siebert | | | | 18. Mother's Name (First, Middle, Maiden Surname) Treva Z. Eckert | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Faye Marie Siebert/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13634 Ivy Way, Hagerstown, Maryland 21740 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | Date Jun. 16 | | 20c. Location - City or Town, State Hagerstown, Maryland | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 | | | | | |
| 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Poorly Differential Adenocarcinoma Lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 6 months | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D01062 | | 29d. Date signed (Month, Day, Year) July 14, 1999 | | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 21740 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24091

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Luella Mary SNYDER

2. Date of Death

Month Day Year
July 11, 1999

3. Time of Death

5:20 a.m.

4a. Facility Name (If not institution, give street and number)

Colton Villa Nursing Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

187-16-4678

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 28, 1917

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

815 Georgia Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housekeeping

16b. Kind of Business/Industry

hospital

17. Father's Name (First, Middle, Last)

Harsh Philpott

18. Mother's Name (First, Middle, Maiden Surname)

Irene Ann Woolsey

19a. Informant's Name/Relationship (Type, Print)

Charles Snyder - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

700 Georgia Avenue, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

7-14-99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic CARDIOVASCULAR DISEASE

MIWS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Insulin Dependent Diabetes

54 years

Due to (or as a consequence of):

c. CEREBROVASCULAR DISEASE

2 years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D28365

29d. Date signed (Month, Day, Year)

7-12-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MANZAR J SHAH 368 MILL STREET HAGERSTOWN MD 21740

State
Registrar

31. Date filed (Month, Day, Year)

JUL 13 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24092

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Louise SAUM | | | | 2. Date of Death Month Day Year JULY 10 1999 | | | | 3. Time of Death 10:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) COFFMAN NURSING HOME | | | | 4b. City, Town, or Location of Death Hagerstown | | | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 218-62-8626 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) July 30, 1911 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 141 Elm Street | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | | 16b. Kind of Business/Industry her own home | | |
| | 17. Father's Name (First, Middle, Last) Keller Newton Morin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie Mort | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Betty L. Sama - daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13530 Paradise Dr., Hagerstown, Md. 21742 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery | | Date 7-13-99 | | 20c. Location - City or Town, State Hagerstown, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Scott M. Minnich | | | | 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 months | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier Samuel Chan, MD | | | | 29c. License number D36655 | | 29d. Date signed (Month, Day, Year) July 12, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL CHAN, M.D. 1185 Mt Aetna Rd. HAGERSTOWN, MD 21740 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 13 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24093

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---------------------------|---|--|--|--|--|--|
| Physician Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marilyn Alberta SISK | | | | 2. Date of Death Month Day Year July 9 1999 | | 3. Time of Death 0340 | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 009-12-5783 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 72 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 23, 1927 | |
| | 9. Birthplace (State or Foreign Country) Vermont | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 12140 Hopewell Road | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | 16b. Kind of Business/Industry her own home | | |
| 17. Father's Name (First, Middle, Last) unknown | | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Tina Rauth/daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12140 Hopewell Road, Hagerstown, Maryland 21740 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory | | Data July 10, 1999 | | 20c. Location - City or Town, State Hagerstown, Maryland | |
| 21. Signature of Funeral Service Licensee Scott Minnich | | | | | 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Cancer Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death Unknown 20 years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 26e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and Title of Certifier MD | | | | | 29c. License number D47288 | | 29d. Date signed (Month, Day, Year) 07.10.1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Iqbal 12821 Oak Hill Avenue Hagerstown Maryland | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 13 1999 | | | 32. Registrar's Signature G. Spores | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


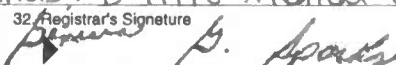
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24094

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Amel SHULTZ | | | | 2. Date of Death Month Day Year July 17, 1999 | | | | 3. Time of Death 3:45 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Williamsport Nursing Home | | | | 4b. City, Town, or Location of Death Williamsport | | | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 264-42-5149 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 41 Yrs. | | 8. Date of Birth (Month, Day, Year) July 28, 1927 | | 9. Birthplace (State or Foreign Country) Texas | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 351 Radcliffe Avenue | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) sander | | | | 16b. Kind of Business/Industry furniture | |
| | 17. Father's Name (First, Middle, Last) Major Amel Shultz | | | | 16. Mother's Name (First, Middle, Maiden Surname) Lula Gregory | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Judith A. Semler - niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10805 Roessner Avenue, Hagerstown, Md. 21740 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | Date 7-20-99 | | 20c. Location - City or Town, State Hagerstown, Maryland | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. aspiration pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. seizure disorder Due to (or as a consequence of): c. cerebrovascular accident Due to (or as a consequence of): d. Approximate Interval Between Onset and Death weeks years years | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension, anemia, hypoproteinemia | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Cynthia Kuttner - Sands, MD | | | | | | | | | | |
| 29c. License number D 4745 | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) July 18, 1999 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Kuttner - Sands, MD 11110 Medical Campus Road, Suite 130, Hagerstown, Maryland 21742 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 19 1999 | | | | | | | | | | |
| 32. Registrar's Signature  | | | | | | | | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24095

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Louise Shaffer

2. Date of Death

Month
JulyDay
16

3. Time of Death

Year
1999

3:55 PM

4a. Facility Name (If not institution, give street and number)

8104 Neck Road

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

219-12-0121

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

May 15, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8104 Neck Road

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Aircraft Manufacturer

17. Father's Name (First, Middle, Last)

Robert Jacob Welty

18. Mother's Name (First, Middle, Maiden Surname)

Lula Grace Lizer

19a. Informant's Name/Relationship (Type, Print)

Jerry Slonaker/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16780 Taylor's Landing Road Sharpsburg, Maryland 21782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenlawn Memorial Park

Date

7-20-99

20c. Location - City or Town, State

Williamsport, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home
425 S. Conococheague St. Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Poorly Differentiated Bronchogenic Carcinoma

6-8 months

Due to (or as a consequence of):

with metastasis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01062

29d. Date signed (Month, Day, Year)

July 19, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24096

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JERRY NMN SUK | | | | 2. Date of Death Month Day Year July 09 1999 | | 3. Time of Death 2212 | |
| | 4a. Facility Name (If not Institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington Co. | |
| Funeral Director | 5. Social Security Number 139-22-3204 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) April 21, 1909 | |
| | 9. Birthplace (State or Foreign Country) New Jersey | | 10a. State Maryland | | 10b. County Washington County | | 10c. City, Town or Location Hagerstown | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 19816 Evelyn Avenue | | 10f. Zip Code 21742 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | 16b. Kind of Business/Industry Agricultural Farmer | | |
| 17. Father's Name (First, Middle, Last) Louis Suk | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maria Klima | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Emily Sodano, Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19816 Evelyn Avenue, Hagerstown, Maryland 21742 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery | | 20c. Date July 14 | | 20d. Location - City or Town, State Vineland, New Jersey | | |
| 21. Signature of Funeral Service Licensee Kelly A. Zimmerman | | | | 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Edema Due to (or as a consequence of): Renal failure Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic obstructive pulmonary disease Due to (or as a consequence of): Approximate Interval Between Onset and Death (4) days (4) days (15) years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier [Signature] MD | | 29c. License number D 47288 | | 29d. Date signed (Month, Day, Year) 07, 10, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Iqbal 12821 Oak Hill Avenue Hagerstown Maryland | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 12 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Emil Edwin Swanson

2. Date of Death

July 13, 1999

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

7628 Woodbine Rd.

4b. City, Town, or Location of Death

Woodbine

4c. County of Death

Carroll

5. Social Security Number

220-18-1480

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 16, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7628 Woodbine Rd.

10f. Zip Code

21797

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1945-194713. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maryland State

16b. Kind of Business/Industry

Highway Administration

17. Father's Name (First, Middle, Last)

Emil Swanson

18. Mother's Name (First, Middle, Maiden Sumama)

Mamie Conaway

19a. Informant's Name/Relationship (Type, Print)

Ruth Swanson - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7628 Woodbine Rd. Woodbine, MD 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ebenezer U.M. Cem.

Date

July 16, 1999 Winfield, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burrier-Queen Fuenral Home
1212 West Old Liberty Rd. Winfield, MD 2178423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

End Stage Coronary artery disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 years

b.

Congestive Heart Failure

Due to (or as a consequence of):

6 mos.

c.

End stage

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, cerebro
vascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kaufman MD

29c. License number

D38915

29d. Date signed (Month, Day, Year)

7/14/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

FREIS

295 Stoner Ave

Westminster MD 21157

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

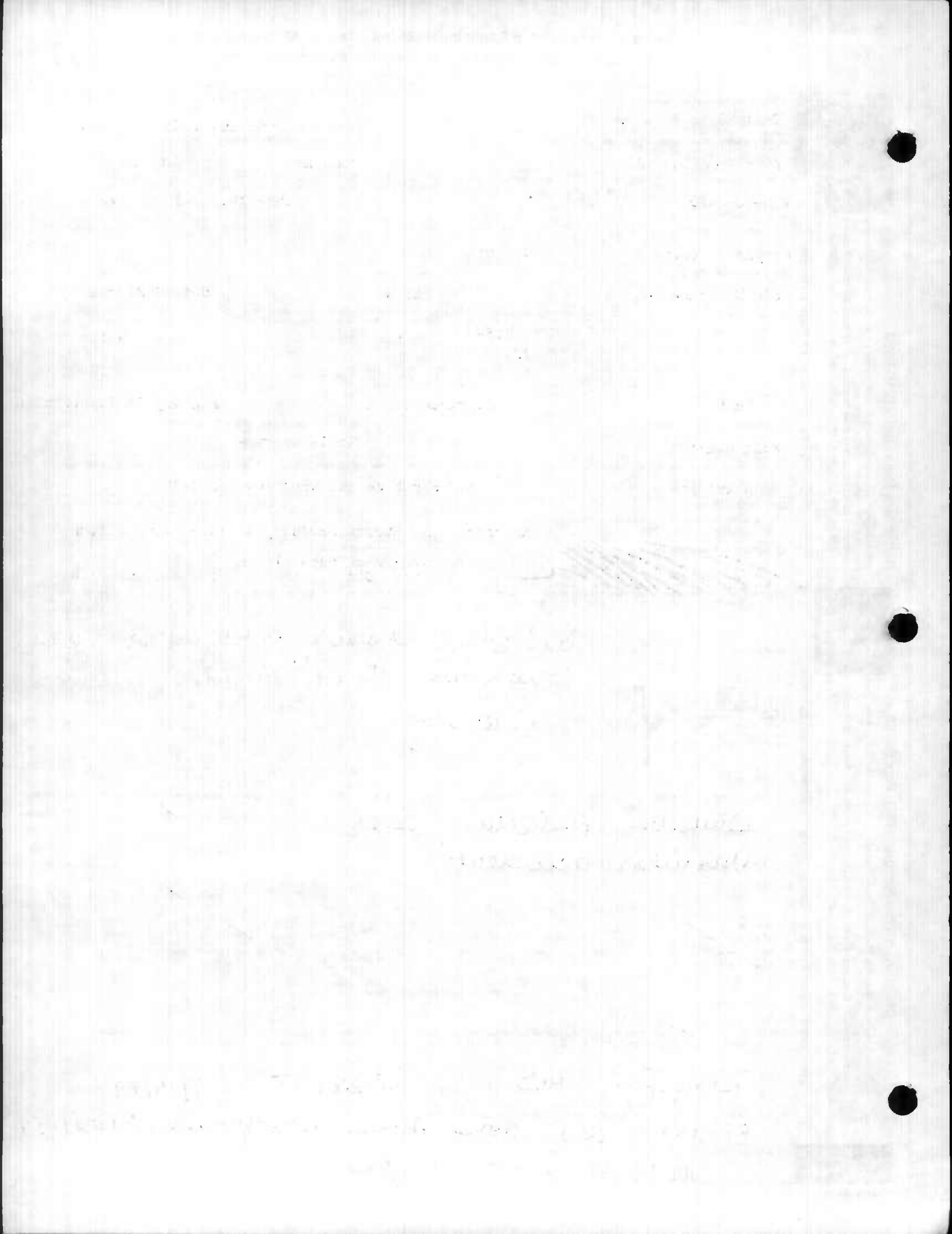
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24098

| | | | | | | | | |
|---|---|---|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Bernice Leona TRUMPOWER | | | | 2. Date of Death Month Day Year JULY 20 1999 | | 3. Time of Death 0545 | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 219-12-1770 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) July 26, 1914 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 11 W. Baltimore Street | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) factory worker | | 16b. Kind of Business/Industry leather company | | 17. Father's Name (First, Middle, Last) Ottmer Berry Smith | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Gertie Lee Overstreet | | 19a. Informant's Name/Relationship (Type, Print) Maxwell J. Miller - son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13720 Lois St., Hagerstown, Md. 21740 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery | | 20c. Location - City or Town, State 7-22-99 Hagerstown, Maryland | | 21. Signature of Funeral Service Licensee <i>Scott M. Minnich</i> | | 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Constrictive Heart Failure Due to (or as a consequence of): c. Arterio Sclerotic Cardiovascular Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 2 weeks 2 weeks ms | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension cerebrovascular Accidents Peripheral Vascular Disease | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) M | | 28b. Time of Injury 1 Yes 2 <input type="checkbox"/> No | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number 018019 | | 29d. Date signed (Month, Day, Year) JULY 20, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown Md 21740 | | |
| 31. Date filed (Month, Day, Year) JUL 22 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | State Registrar | | Baltimore, Maryland 21215-0020 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

July 20, 1945

Dear Mr. [Name]
[Address]
[City, State, Zip]

Enclosed

is a copy of [document]

for your information.

Sincerely,
[Signature]

[Name]

[Title]

[Organization]

[Address]

[City, State, Zip]

[Phone Number]

[Fax Number]

[E-mail Address]

[Web Address]

[Social Media]

[Other Contact Info]

[Additional Info]

[Closing Remarks]

[Final Sign-off]

[Page Number]

[Date]

[Time]

[Location]

[Weather]

[Mood]

[Thoughts]

[Concluding Remarks]

[Final Note]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24099

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Lou Townshend

2. Date of Death

Month Day Year
July 18, 1999

3. Time of Death

1:32 pm.

4a. Facility Name (If not institution, give street and number)

704 Alamo Lane

4b. City, Town, or Location of Death

Lusby

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

577-50-9407

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
4/5/37

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

XX Yes 2 ☐ No

10a. Street and Number

704 Alamo Lane

10f. Zip Code

20657

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

clerk

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Walter B. Kaczorek

18. Mother's Name (First, Middle, Maiden Surname)

Erma Louise Faber

19a. Informant's Name/Relationship (Type, Print)

Daniel Townshend/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

704 Alamo Lane, Lusby, MD 20657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

S. Memorial Gdns.

Date

7/22/99

20c. Location - City or Town, State

Dunkirk, MD

21. Signature of Funeral Service Licensee

Michael O. Kaczmarek

22. Name and Address of Facility

Raymond Funeral Home, PA
P.O. Box 121, Dunkirk, MD 2075423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Carcinoma Lung.

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

8 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 8 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Zahir Yousaf, M.D.

29c. License number

D 27189

29d. Date signed (Month, Day, Year)

7-19-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Zahir Yousaf, M.D. 2417 Solomons Island Rd. Huntingtown, Md 20638

31. Date filed (Month, Day, Year)

7-19-99 JUL 20 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24100

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Julia Meta WILLIAMSON | | | | 2. Date of Death Month Day Year July 16, 1999 | | | | 3. Time of Death 6:25 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Colton Villa Nursing Home | | | | 4b. City, Town, or Location of Death Hagerstown | | | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 213-74-1948 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 103 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 1, 1896 | | 9. Birthplace (State or Foreign Country) Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 805 Dale Street | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 Collega (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | | | 16b. Kind of Business/Industry her own home | |
| | 17. Father's Name (First, Middle, Last) James Templon | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hettie Mummert | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Margaret Kershner - daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Dale Street, Hagerstown, Md. 21740 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | Date 7-19-99 | | 20c. Location - City or Town, State Hagerstown, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic obstructive lung disease Due to (or as a consequence of): b. Atherosclerotic cardiovascular dis. Due to (or as a consequence of): c. Chronic renal insufficiency Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| Physician /Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier M.D. | | | | 29c. License number D0041131 | | 29d. Date signed (Month, Day, Year) 7/16/99 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JERRY L. CORROCHES, M.D. 338 Mill St. Hagerstown, MD 21740 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24101

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN C. WOLFES

2. Date of Death

Month Day Year

July 7, 1999

3. Time of Death

4:30 PM

4a. Facility Name (If not institution, give street and number)

REEDER'S NURSING HOME

4b. City, Town, or Location of Death

BOONESBORO

4c. County of Death

WASHINGTON

Funeral
Director

5. Social Security Number

232-54-3440

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 12, 1910

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

WV

10b. County

BERKELEY

10c. City, Town or Location

MARTINSBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

220 N. SPRING STREET

10f. Zip Code

25401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

WATCH MAKER

16b. Kind of Business/Industry

WOLFES JEWELRY

17. Father's Name (First, Middle, Last)

GILBERT RUSSELL LITTEN

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES MINNICK

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA W. SMALL/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9712 DRIFTWOOD LANE, HAGERSTOWN, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GREEN HILL CEMETERY

Date

7/9/99

20c. Location - City or Town, State

MARTINSBURG, WV

21. Signature of Funeral Service Licensee

Charles M. Brown

22. Name and Address of Facility

BROWN FUNERAL HOME, 327 W. KING ST.
PO BOX 821, MARTINSBURG, WV 2540223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pneumonia
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 wks

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Aspiration
Due to (or as a consequence of):

4 wks

c. Dementia
Due to (or as a consequence of):

yrs

d. Stroke
Due to (or as a consequence of):

yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be
3 ☐ Suicide 4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Zafar Malik

29c. License number

D44996

29d. Date signed (Month, Day, Year)

July 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713 (301) 432-8470

State
Registrar

31. Date filed (Month, Day, Year)

JUL 12 1999

32. Registrar's Signature

B. Spahr

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Name: Evelyn Cathleen Wolfes
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24102

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|-------------------------------|--|--|--|--|--|--|---|----|---------------------------|--|----------------------------------|--|---------|----|------------------------|--------|----------------------------------|--|--------|--|----|--------|--------|----------------------------------|--|--------|----|-----------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Adeline Mary Wogen | | | | 2. Date of Death Month Day Year July 14, 1999 | | | | 3. Time of Death 22:50 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Carroll County General Hospital | | | | 4b. City, Town, or Location of Death Westminster | | | | 4c. County of Death Carroll | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 324-09-5486 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) May 31 1912 | | 9. Birthplace (State or Foreign Country) Wisconsin | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Carroll | | 10c. City, Town or Location Westminster | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 108 Willis Street | | | | 10f. Zip Code 21157 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Ernest L. Dahl | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rose Fleck | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Kristin Vandervalk/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 Willis Street Westminster, MD 21157 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremations | | Date 7/15/99 | | 20c. Location - City or Town, State Hampstead, MD | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd., Westminster, MD 21157 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Metastatic Ovarian Cancer</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td>1 month</td> </tr> <tr> <td>b.</td> <td>Gastrointestinal Bleed</td> <td>8 days</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td>8 days</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td>Anemia</td> <td>8 days</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td>5 days</td> </tr> <tr> <td>d.</td> <td>Pneumonia</td> <td></td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Metastatic Ovarian Cancer | Approximate Interval Between Onset and Death | Due to (or as a consequence of): | | 1 month | b. | Gastrointestinal Bleed | 8 days | Due to (or as a consequence of): | | 8 days | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | Anemia | 8 days | Due to (or as a consequence of): | | 5 days | d. | Pneumonia | |
| Immediate Cause (Final disease or condition resulting in death) | a. | Metastatic Ovarian Cancer | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | 1 month | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | Gastrointestinal Bleed | 8 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | 8 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | Anemia | 8 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | 5 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | Pneumonia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Lisa Kim, M.D. | | | | 29c. License number D52479 | | 29d. Date signed (Month, Day, Year) July 14, 1999 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lisa Kim, M.D. at Carroll County General Hospital at 200 Memorial Avenue, Westminster, MD 21157 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24103

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

NELLIE ELIZABETH SAWYER WILSON

2. Date of Death

July 16, 1999

3. Time of Death

2300

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

215-26-3975

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3/4/30

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

9723 Stephen Decatur Highway

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

Collega (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dishwasher

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

James Edward Casper

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Jane Hudson

19a. Informant's Name/Relationship (Type, Print)

Charles Sawyer / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Graham Ave. Berlin, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

7/20/99

20c. Location - City or Town, State

Berlin, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burbage Funeral Home
108 William St. Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42075

29d. Date signed (Month, Day, Year)

JULY 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EMMANUEL NSAH, PENINSULA CARDIOLOGY, 400 E. SHORE SALISBURY, MD

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

W. J. [unclear]

X

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24104

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jacob Edgar Weaver Jr

2. Date of Death

July 20

Day

Year

1999

3. Time of Death

4:22PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

218-05-2212

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov. 1, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

15 Yes 2 No

10e. Street and Number

207 S Main St

10f. Zip Code

21639

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Jacob Edgar Weaver Sr

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Blackburn

19a. Informant's Name/Relationship (Type, Print)

Ethel Marie Weaver/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

207 S. Main St Greensboro, Maryland 21639

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greensboro Cemetery

Date

July 23, 1999

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home PA
PO Box 160 Greensboro, Maryland 2163923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. RUPTURED ABDOMINAL AORTIC ANEURYSM

Approximate
Interval Between
Onset and Death

HOURS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HISTORY OF CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation
6 Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 48064

29d. Date signed (Month, Day, Year)

July 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin Stitely 505 Dutchman's Lane Easton, Maryland 21601

State
Registrar

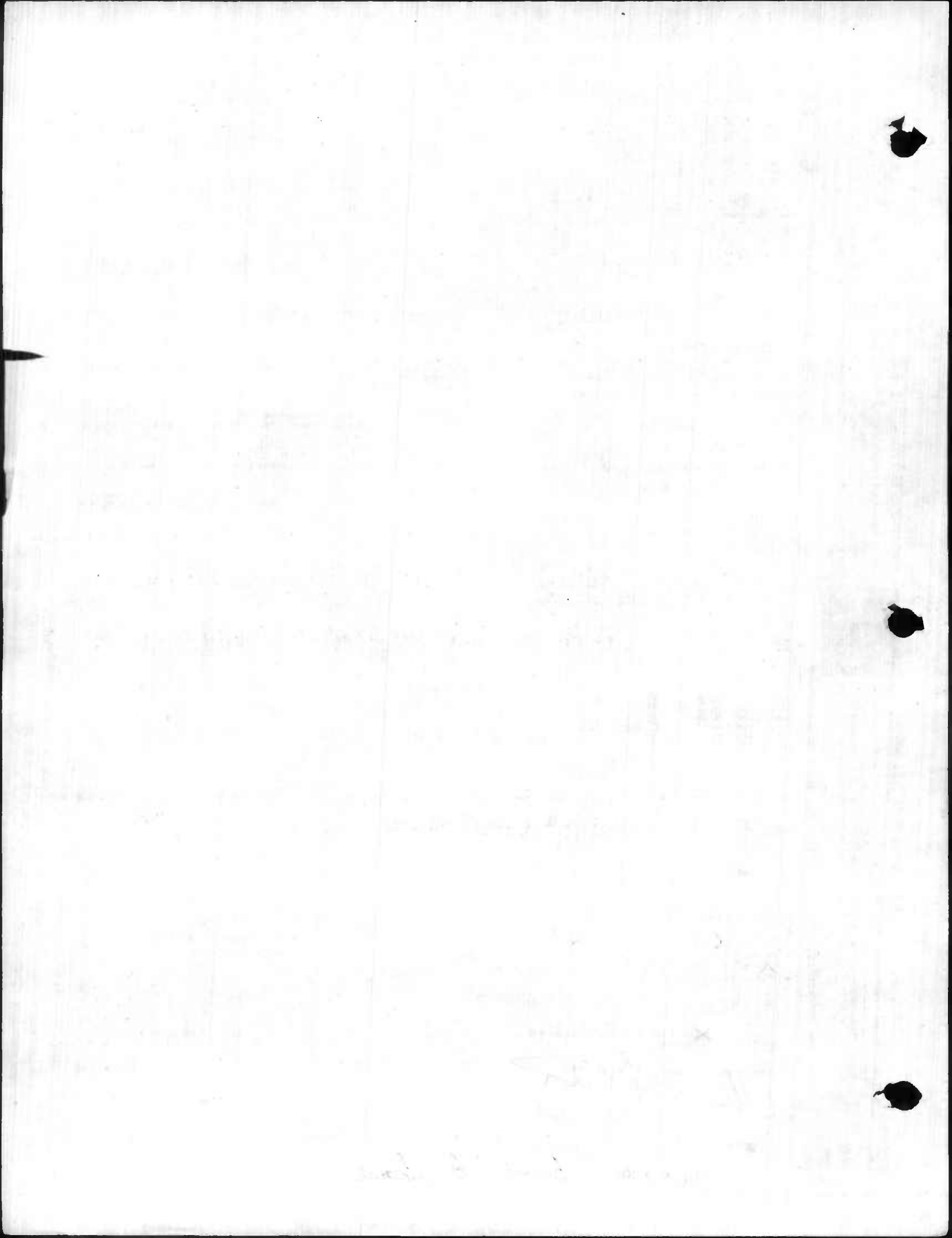
31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

B. Sparks

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24105
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS DELL ARNIEL

2. Date of Death

Month Day Year
JULY 28 1999

3. Time of Death

08:30 PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

219-20-5262

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

3/6/28

9. Birthplace (State or Foreign Country)

MISSOURI

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8111 BARKSDALE ROAD

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JAMES MARION DAVIS

18. Mother's Name (First, Middle, Maiden Surname)

MARIE JANE ARTHUR

19a. Informant's Name/Relationship (Type, Print)

KATHLEEN ARNIEL DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8111 BARKSDALE ROAD TOWSON, MD 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY MEM. GAR.

Date

7/31/99

20c. Location - City or Town, State

COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. intestinal ischemia, sepsis.

Due to (or as a consequence of):

b. stercoral colitis

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Fecal impaction

Due to (or as a consequence of):

d. coronary artery disease

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failureRespiratory Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D19637

29d. Date signed (Month, Day, Year)

7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N CHARLES ST TOWSON, MD 21204

State
Registrar

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24106

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Beatrice Alexander

2. Date of Death

Month Day Year
JULY 26th 1999

3. Time of Death

6:40pm

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

216-28-1312

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
09-29-28

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1648 Burnwood Road

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th GradeCollege (1-4or 5+)
2yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registra Nurse

16b. Kind of Business/Industry

Nursing Co.

17. Father's Name (First, Middle, Last)

Emmitt Ellis

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Roberts

19a. Informant's Name/Relationship (Type, Print)

Andrea Moseley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

921 Dartmouth Glen Way Baltimore, MD. 21212

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Cemetery

Date

08-02-99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ISCHEMIC ENCEPHALOPATHY

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

ANU GABA MD

29c. License number

P-12560

29d. Date signed (Month, Day, Year)

July 26th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANU GABA, RESIDENT, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD

State
Registrar

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

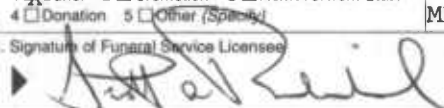
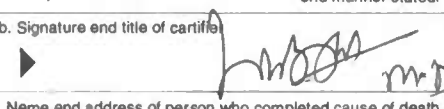
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24107

| | | | | | | | | |
|--|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DOROTHY ELIZABETH BALLMAN | | | | 2. Date of Death Month Day Year AUGUST 01 1999 | | 3. Time of Death 1-50PM | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 212-20-9026 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAY 13, 1926 | | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 306 ROOSEVELT AVE. | | | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? UNITED STATES | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | |
| 17. Father's Name (First, Middle, Last) GILBERT L. LEISHER | | | | | 18. Mother's Name (First, Middle, Maiden Surname) EMMA A. ROBERTSON | | | |
| 19a. Informant's Name/Relationship (Type, Print) SYDNEY BALLMAN/HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 ROOSEVELT AVE. GLEN BURNIE, MD 21061 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEM. PARK | | 20c. Location - City or Town, State ELKRIDGE, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ATHEROSCLEROTIC CORONARY VASCULAR DISEASE Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d. PNEUMONIA | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  MD | | | | 29c. License number D51664 | | 29d. Date signed (Month, Day, Year) AUGUST 01 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR KUMAR AGGARWAL NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | | | 32. Registrar's Signature  | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24108**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|---|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ruth E. Blackburn | | | | | 2. Date of Death Month July Day 31 Year 1999 | | | 3. Time of Death 7:56 AM | |
| | 4a. Facility Name (If not institution, give street and number) Howard County General Hospital | | | | | 4b. City, Town, or Location of Death Columbia | | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 251-58-0290 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-20-1939 | | 9. Birthplace (State or Foreign Country) S. C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Elkridge | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 6699 Deep Run Parkway | | | | 10f. Zip Code 21075 | | 10g. Citizen of What Country? U. S. A | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Correctional officer | | | 16b. Kind of Business/Industry Prison | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Eddie Myers | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Allie Bess Timmons | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Lillian M. George - Sister | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10083 Hatbim Terrace Columbia, MD 21046 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Date 8-2-99 | | 20d. Location - City or Town, State Catonsville, MD | | | |
| | 21. Signature of Funeral Service Licensee Gabrielle Cook | | | | | 22. Name and Address of Facility March F.H. West 4300 Wabash Avenue Baltimore, MD 21215 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Pneumonia Due to (or as a consequence of): b. Congestive heart failure Due to (or as a consequence of): c. Interstitial pneumonia Due to (or as a consequence of): d. restrictive cardiomyopathy | | | | | | | | Approximate Interval Between Onset and Death 1wk 1wk years 1wk | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure Adult onset diabetes | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| State Registrar | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier David Jackson, MD | | 29c. License number D35217 | | 29d. Date signed (Month, Day, Year) July 31 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID JACKSON, MD Suite #210 Columbia, MD 21044 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature James B. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24109

| | | | | | |
|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALEKSANDRA CHUMIKOVA | | 2. Date of Death Month <u>July</u> Day <u>25</u> Year <u>1999</u> | | 3. Time of Death <u>12 45</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>SINAI Hospital of Baltimore</u> | | 4b. City, Town, or Location of Death <u>BALTIMORE</u> | | 4c. County of Death <u>N/A</u> |
| Funeral Director | 5. Social Security Number <u>217-25-9246</u> | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>76</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <u>APR. 18, 1923</u> | | 9. Birthplace (State or Foreign Country) <u>UKRAINE</u> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State <u>MD</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>BALTIMORE</u> | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 10e. Street and Number <u>5900 PARK HEIGHTS AVENUE #508</u> | | | 10f. Zip Code <u>21215</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOUSEWIFE</u> | | 16b. Kind of Business/Industry <u>OWN HOME</u> | |
| 17. Father's Name (First, Middle, Last) <u>GEORGE CHUMIKOV</u> | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>KATHERINE PIVOPOVA</u> | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>YAKOV DEKHTYAR / HUSBAND</u> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5900 PARK HEIGHTS AVE. #508 - BALTIMORE, MD 21215</u> | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>BALTIMORE HEBREW CEMETERY</u> | | 20c. Location - City or Town, State <u>7/27/99 REISTERSTOWN, MD</u> | |
| 21. Signature of Funeral Service Licensee <u>Jerry Clau Lee</u> | | 22. Name and Address of Facility <u>SOL LEVINSON & BROS., INC.</u> <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. <u>Hypovolemia</u> Due to (or as a consequence of): b. <u>Anemia</u> Due to (or as a consequence of): c. <u>GASTROINTESTINAL BLEED</u> Due to (or as a consequence of): d. <u></u> | | | | | |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>End stage Renal Disease, Respiratory Failure</u> <u>Non-Insulin Dependent Diabetes Mellitus, Sepsis</u> | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Were an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) <u></u> | | 28b. Time of Injury <u>M</u> | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and Title of certifier <u>RES UOO</u> | | 29c. License number <u>RES UOO</u> | | 29d. Date signed (Month, Day, Year) <u>July 25, 1999</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>ANDREW MORTAL SINAI Hospital of Baltimore</u> | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 2 1999</u> | | 32. Registrar's Signature <u>Anna B. Sparks</u> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24110

| | | | | | | | | | | | | | | | | |
|--|--|---|--|--|-------------------------------------|---|----|---------------|----------------------------------|--|----|--|----|--|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ERNEST CLINTON | | 2. Date of Death Month July Day 30 Year 1999 | | 3. Time of Death 10:20 AM | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 246-30-2557 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | | | | | | | | | | | |
| | 8. Date of Birth (Month, Day, Year) 10-03-24 | | 9. Birthplace (State or Foreign Country) NC | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | | | | | | | | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 10e. Street and Number 5611 Govane Avenue | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver | | 16b. Kind of Business/Industry Pimlico Race Track | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Joseph Clinton | | 18. Mother's Name (First, Middle, Maiden Sumama) Viola Lee | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marion Miles-Ingram | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Govane Avenue Baltimore, Maryland 21212 | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery | | 20c. Location - City or Town, State 08-02-99 Baltimore, MD | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Sepsis</td> <td rowspan="4"> Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death 2 </td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table> | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Sepsis | Due to (or as a consequence of): | Approximate Interval Between Onset and Death 2 | b. | | c. | | d. | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Sepsis | Due to (or as a consequence of): | Approximate Interval Between Onset and Death 2 | | | | | | | | | | | | |
| | b. | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. HYPERTENSION, DIABETES | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | | | | | | | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number P11391 | | 29d. Date signed (Month, Day, Year) July 30, 1999 | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHEL SKAF 5601 Loch Raven Blvd Baltimore MD 21239 | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24111

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Aloysius Penn Carter, Sr

2. Date of Death

Month
07Day
26Year
99

3. Time of Death

8:00 A.M.

4a. Facility Name (If not institution, give street and number)

3718 Gelston Drive

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

217-01-0607

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7-10-1909

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3718 Gelston Drive

10f. Zip Code

21229

10g. Citizen of What Country?

U. S. A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th grade

College (14 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Pipe Fitter

16b. Kind of Business/Industry

Bethlehem steel

17. Father's Name (First, Middle, Last)

James Carter

18. Mother's Name (First, Middle, Maiden Surname)

Mary Carter

19a. Informant's Name/Relationship (Type, Print)

Bertha Carter - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3718 Gelston Drive Baltimore, md 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Houder Park Cemetery

Date

7-31-99

20c. Location - City or Town, State

Baltimore, md

21. Signature of Funeral Service Licensee

Shannon Stokes

22. Name and Address of Facility

March F.H. West
4300 Wabash Avenue Balto, md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Paget disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Mrowiec M.D.

29c. License number

D 47804

29d. Date signed (Month, Day, Year)

07/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Mrowiec 530 N. HILTON JTR BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

Shannon Stokes

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, 7

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24112**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---------------------------------|---|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANCES M. CRAIG | | | | | 2. Date of Death Month JULY Day 30th Year 1999 | | | 3. Time of Death 8:35 PM | |
| | 4a. Facility Name (If not institution, give street and number) Northwest Hospital Center | | | | | 4b. City, Town, or Location of Death Randallstown | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 216-18-7151 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 18, 1915 | | 9. Birthplace (State or Foreign Country) England | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Reisterstown | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 122 Nicodemus Rd. | | | | | 10f. Zip Code 21136 | | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator | | | | 16b. Kind of Business/Industry Social Security Adm. | | |
| 17. Father's Name (First, Middle, Last) Thomas Nichols | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Mennon | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James E. Ripley, Jr. - Nephew | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Nicodemus Rd., Reisterstown, Md. 21136 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park Aug. 3, 1999 Baltimore, Md. | | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</p> <p>Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and Title of Certifier  | | | | | 29c. License number D42723 | | | 29d. Date signed (Month, Day, Year) JULY 30th 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AVVERA HAWI M HARISH: 3745 FOXFORD STREAM RD BALTIMORE MD 21236 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | | | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Bellevue Hospital Center
1001, 1015
1977-1978

Bellevue Hospital Center
1001, 1015
1977-1978
Bellevue Hospital Center
1001, 1015
1977-1978

Bellevue Hospital Center
1001, 1015
1977-1978
Bellevue Hospital Center
1001, 1015
1977-1978
Bellevue Hospital Center
1001, 1015
1977-1978

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24113

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Martha Dingind</i> | | 2. Date of Death Month <i>July</i> Day <i>30</i> Year <i>1999</i> | | 3. Time of Death <i>725 PM</i> |
| | 4a. Facility Name (If not institution, give street and number) <i>Keswick Multi Care Center</i> | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> |
| Funeral Director | 5. Social Security Number <i>579-22-3249</i> | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>82</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <i>09-16-1916</i> | | 9. Birthplace (State or Foreign Country) <i>Virginia</i> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10a. State <i>Md.</i> | 10b. County <i>N/A</i> | <i>Baltimore</i> | | |
| | 10e. Street and Number <i>4401 Roland Avenue</i> | | 10f. Zip Code <i>21210</i> | | 10g. Citizen of What Country? <i>USA</i> |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12 th</i> Collage (1-4 or 5+) <i>6 Years</i> | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teacher</i> | | 16b. Kind of Business/Industry <i>Education</i> | | |
| | 17. Father's Name (First, Middle, Last) <i>David Higginbotham</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Amanda McDaniel</i> | | |
| | 19e. Informant's Name/Relationship (Type, Print) <i>Charlene Gregg (Cousin)</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7736 Rockledge Ct. Springfield Va. 22152</i> | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery</i> | | 20c. Location - City or Town, State <i>7/3/99 Woodlawn, Maryland</i> |
| | 21. Signature of Funeral Service Licenses <i>Dennis B. Caple</i> | | 22. Name and Address of Facility <i>Caple Funeral Service 5502 Winner Ave. Balto., Md. 21215</i> | | |
| Physician /Medical Examiner | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Coronary artery disease</i> Due to (or as a consequence of): <i>b. Atherosclerosis</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i> | | | | Approximate Interval Between Onset and Death <i>unknown</i> <i>unknown</i> |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier <i>M. Isabelle MacGregor MD</i> | | 29c. License number <i>D13657</i> | | 29d. Date signed (Month, Day, Year) <i>July 31, 1999</i> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DR ISABELLE MAC GREGOR, KESWICK, 702 W. 40th STREET, BALTIMORE MD 21211</i> | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <i>AUG 2 1999</i> | | 32. Registrar's Signature <i>B. Sparks</i> | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND#11& 18 PER A.B. G776

State of Maryland / Department of Health and Mental Hygiene

10-28-99 J.A.

AMENDED ITEM #24 & #25 PER ME G774 8/2/99 AH

Certificate of Death

Reg. No.

99 24114

| | | | | | | | | |
|--|---|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Warren M. Dunham | | | | 2. Date of Death Month Day Year July 10 1999 | | 3. Time of Death 9:30 pm | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 578-22-2000 | | 6. Sex 123 M 20 F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 28, 1923 | |
| | 9. Birthplace (State or Foreign Country) Va. | | 10. Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Rockville 10d. Inside City Limits 10 Yes 20 No | | 11. Street and Number 299 Hurley Avenue | | 12. Zip Code 20850 | |
| 13. Merital Status 10 Never Married 20 Married 30 Widowed 40 Divorced 20 Married | | 14. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No If Yes, Give Year or Dates: 6/42-1/46 | | 15. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No Specify: 20 No | | 16. Race - American Indian, Black, White, etc. Specify: white | | |
| 17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown | | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | 19. Kind of Business/Industry unknown | | 20. Father's Name (First, Middle, Last) Ray Dunham | | |
| 21. Mother's Name (First, Middle, Maiden Surname) Blanche Reeves SLINGERLAND | | 22. Informant's Name/Relationship (Type, Print) unknown | | 23. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown | | 24. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify) in state | | |
| 25. Place of Disposition (Name of cemetery, crematory or other place) unknown | | 26. Date unknown | | 27. Location - City or Town, State unknown | | 28. Signature of Funeral Service Licensee Ronald S. Wade, Director | | |
| 29. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | 30. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute renal failure Due to (or as a consequence of): Sepsis Aspiration Pneumonia Due to (or as a consequence of): Oropharyngeal Carcinoma | | 31. Approximate Interval Between Onset and Death Two days three days four days two years | | 32. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | |
| 33. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown 10 Yes | | 34. Were an autopsy performed? 10 Yes 20 No 20 No | | 35. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No 20 No | | 36. Was case referred to medical examiner? 10 Yes 20 No 20 No | | |
| 37. Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA 10 Inpatient | | 38. Other: 40 Nursing Home 50 Residence 60 Other (Specify) 40 Nursing Home | | 39. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined 10 Natural | | 40. Date of Injury (Month, Day, Year) 28 July 1999 | | |
| 41. Time of Injury M | | 42. Injury at Work? 10 Yes 20 No 20 No | | 43. Describe how injury occurred | | 44. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 45. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home | | 46. Location (Street and Number or Rural Route Number, City or Town, State) 15201 Shady Grove Rd, #202, Rockville, MD 20850 | | 47. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10 Certifying Physician | | 48. Signature and title of certifier [Signature] M.D. | | |
| 49. License number 039934 | | 50. Date signed (Month, Day, Year) July 11, 1999 | | 51. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN T. COUNTER MD | | 52. Date filed (Month, Day, Year) AUG 2 1999 | | |
| 53. Registrar's Signature [Signature] | | 54. State Registrar State Registrar | | 55. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 56. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24115

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harold S Dow | | | | 2. Date of Death Month 7 Day 23 Year 1999 | | 3. Time of Death 10:35pm | | |
| | 4a. Facility Name (If not Institution, give street and number) Manor Care Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | | |
| Funeral Director | 5. Social Security Number 164-18-8217 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) 04-20-21 | | |
| | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 4669 Falls Road | | | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) NA | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver | | | 16b. Kind of Business/Industry G.A.F. Company | | |
| 17. Father's Name (First, Middle, Last) Nathaniel Isaac Dow | | | | | 16. Mother's Name (First, Middle, Maiden Surname) Amy Dow | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Carol Dow | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19050 1122 Whitby Avenue Yeadon, Philadelphia | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris Crematory 07-30-99 Wentchester, PA | | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | | |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Cerebro Vascular Accident | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. Hypertension Due to (or as a consequence of): | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier Anil UBERO MD | | 29c. License number D26748 | | 29d. Date signed (Month, Day, Year) 7/27/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anil UBERO MD 4419 FALLS RD BALTO MD 21211 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10-11-1961

10-11-1961

and 10-11-1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24116

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Devreotes

2. Date of Death

Month Day Year
July 31 1999

3. Time of Death

6:50 A.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

088-05-9299

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/11/1916

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8810 Walther Blvd. Apt 2026

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Mignone

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Montifusco

19a. Informant's Name/Relationship (Type, Print)

Peter Devreotes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1408 Ellenglen Road Baltimore, Maryland 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ocean Memorial Park

Date

8/3/99

20c. Location - City or Town, State

Toms River NJ.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock

Due to (or as a consequence of):

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d. Atherosclerosis

Approximate Interval Between Onset and Death

1 Hour

6 Hours

Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D 43083

29d. Date signed (Month, Day, Year)

July 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Gunta A. Wheeler, Franklin Square Hospital Center, 9000 Franklin Square Drive, Baltimore, MD 21237

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

State
Registrar

DEVREOTES, Lucille

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A4415

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24117

| | | | | | | | | | | |
|---|---|--|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Jane H. Early</u> | | | | 2. Date of Death Month <u>July</u> Day <u>28</u> Year <u>1999</u> | | | | 3. Time of Death <u>21:10p</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>THE Johns Hopkins Hospital</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore, City</u> | | | | 4c. County of Death <u>N/A</u> | |
| Funeral Director | 5. Social Security Number <u>214-22-9714</u> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>73</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>APR. 6, 1926</u> | | 9. Birthplace (State or Foreign Country) <u>MD</u> | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <u>MD</u> | | 10b. County <u>BALTIMORE</u> | | 10c. City, Town or Location <u>BALTIMORE</u> | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number <u>7805 SEVEN MILE LANE</u> | | | | 10f. Zip Code <u>21208</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u> | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4</u> College (1-4 or 5+) <u>4</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOMEMAKER</u> | | | 16b. Kind of Business/Industry <u>OWN HOME</u> | | |
| | 17. Father's Name (First, Middle, Last) <u>JULIUS DAVID</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>HOLLY NORA WOLF</u> | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <u>EDWIN EARLY / HUSBAND</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7805 SEVEN MILE LANE - BALTIMORE, MD 21208</u> | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>HILLTOP SERVICE CORP.</u> | | Date <u>7/30/99</u> | | 20c. Location - City or Town, State <u>TOWSON, MD</u> | | | |
| | 21. Signature of Funeral Service Licensee <u>Jay Alan Lewis</u> | | | | 22. Name and Address of Facility <u>SOL LEVINSON & BROS., INC.</u> <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Septic shock</u> Due to (or as a consequence of): b. <u>peripheral vascular disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>End stage renal disease from polycystic kidney disease, coronary artery disease with prior myocardial infarction</u> | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <u>MICOL ROTHMAN MD</u> | | 29c. License number <u>RES-000</u> | | 29d. Date signed (Month, Day, Year) <u>July 28, 1999</u> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MICOL ROTHMAN, MD, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD</u> | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) <u>AUG 2 1999</u> | | | | 32. Registrar's Signature <u>[Signature]</u> | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24118

| | | | | | | | | |
|--|---|---|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Donald Edge | | | | 2. Date of Death Month Day Year July 28, 1999 | | 3. Time of Death 4:50 pm | |
| | 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 260-50-7300 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 65 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 04-07-34 | 9. Birthplace (State or Foreign Country) GA | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 111 N. Milton Avenue | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled | | 16b. Kind of Business/Industry Unemployed | | |
| 17. Father's Name (First, Middle, Last) Zigler Edge | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rosalee Fambro | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Frances Edge | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102-24 184 Street Hollins, NY 11412 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Calverton Nat'l Cem | | Date 08-04-99 | | 20c. Location - City or Town, State Riverhead NY | | |
| 21. Signature of Funeral Service Licensee Bernard D. Johnson | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ruptured Thoracic Aortic Aneurysm Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Govt Hypertension COPD | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier D. Swishell MD | | | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) July 29, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon M. Wells, MD, 600 N. Wolfe St., Baltimore MD 21205 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | | | 32. Registrar's Signature Seneca B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24119**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Walter J Fleming** 2. Date of Death **July 28 1999** 3. Time of Death **8:25 PM**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **Frederick Villa Nursing Home** 4b. City, Town, or Location of Death **Catonsville** 4c. County of Death **Baltimore**

5. Social Security Number **215-07-3899** 6. Sex **152 M 20 F** 7. Age (In yrs. last birthday) **86** Yrs. 8. Date of Birth (Month, Day, Year) **Feb 24, 1913** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Baltimore** 10c. City, Town or Location **Arbutus** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **936 Regina Drive** 10f. Zip Code **21227** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status **100 Never Married 200 Married 300 Widowed 400 Divorced** 12. Was Decedent Ever in U.S. Armed Forces? **100 Yes 200 No** 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) **100 Yes 200 No Specify:** 14. Race - American Indian, Black, White, etc. **Specify: White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12) 10th Grade** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Customer Service** 16b. Kind of Business/Industry **Baltimore Gas & Electric**

17. Father's Name (First, Middle, Last) **Harry Fleming** 18. Mother's Name (First, Middle, Maiden Surname) **Madaline Hittel**

19a. Informant's Name/Relationship (Type, Print) **Joseph W. Fleming (Son)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **936 Regina Drive - Arbutus, Maryland 21227**

20a. Method of Disposition **100 Burial 200 Cremation 300 Removal from State 400 Donation 500 Other (Specify)** 20b. Place of Disposition (Name of cemetery, crematory or other place) **Loudon Park Cemetery** Date **7/31/99** 20c. Location - City or Town, State **Baltimore, Maryland**

21. Signature of Funeral Service Licensee **Joanne D. Shannon** 22. Name and Address of Facility **Hubbard Funeral Home, Inc. 107 Wilkens Avenue - Baltimore, Maryland 21229**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **BRONCHO PNEUMONIA** **TEMPORAL ARTERITIS**

23b. Did tobacco use contribute to the cause of death? **100 Yes 200 No 300 Probably 400 Unknown**

24a. Was an autopsy performed? **100 Yes 200 No** 24b. Were autopsy findings available prior to completion of cause of death? **100 Yes 200 No**

25. Was case referred to medical examiner? **100 Yes 200 No** 26. Place of Death (Check only one) **400 Nursing Home 500 Residence 600 Other (Specify)**

27. Manner of Death **100 Natural 200 Accident 300 Suicide 400 Homicide 500 Pending investigation 600 Could not be determined** 28a. Date of Injury (Month, Day, Year) **7/28/99** 28b. Time of Injury **M** 28c. Injury at Work? **100 Yes 200 No** 28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **At home** 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) **200 Medical Examiner** 29b. Signature and title of certifier **N.B. Vellanki** 29c. License number **D-30469** 29d. Date signed (Month, Day, Year) **July 29 1999**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) **N.B. Vellanki, 9055 Chevalier Drive #100, Ellicott City, MD. 21042**

31. Date filed (Month, Day, Year) **AUG 2 1999** 32. Registrar's Signature **Regina S. Sparks**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

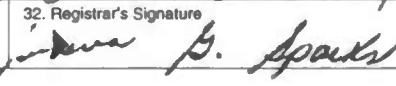
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24120

| | | | | | | | | | |
|--|--|---|--|---|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charlotte Gevantman | | | | 2. Date of Death Month Day Year July 17 1999 | | 3. Time of Death 01:10 | | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 218-01-1916 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 27, 1916 | | |
| | 9. Birthplace (State or Foreign Country) AUSTRIA | | 10a. State MARYLAND | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 3303 GREENVALE ROAD | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +2 YRS. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER | | 16b. Kind of Business/Industry MD STATE POLICE | | 17. Father's Name (First, Middle, Last) REV. JESCHIE MAX | | 18. Mother's Name (First, Middle, Maiden Surname) CLARA GITTLEMAN | |
| 19a. Informant's Name/Relationship (Type, Print) INGRID FISHMAN/ DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 GREENLEAF HILL RD. GREAT NECK, NY 11023 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE EMUNAH-AITZ CHAIM | | 20c. Location - City or Town, State 7/18/99 BALTO. MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON BROS., INC. 8900 REITZERSTOWN ROAD BALTO., MD 21208 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Sigmoid Colon Perforation Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 5 days 5 days | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier  | | 29c. License number RBS 000 | | 29d. Date signed (Month, Day, Year) July 27, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrizia H. M.O. Sinai Hospital of Baltimore | | 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24121

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

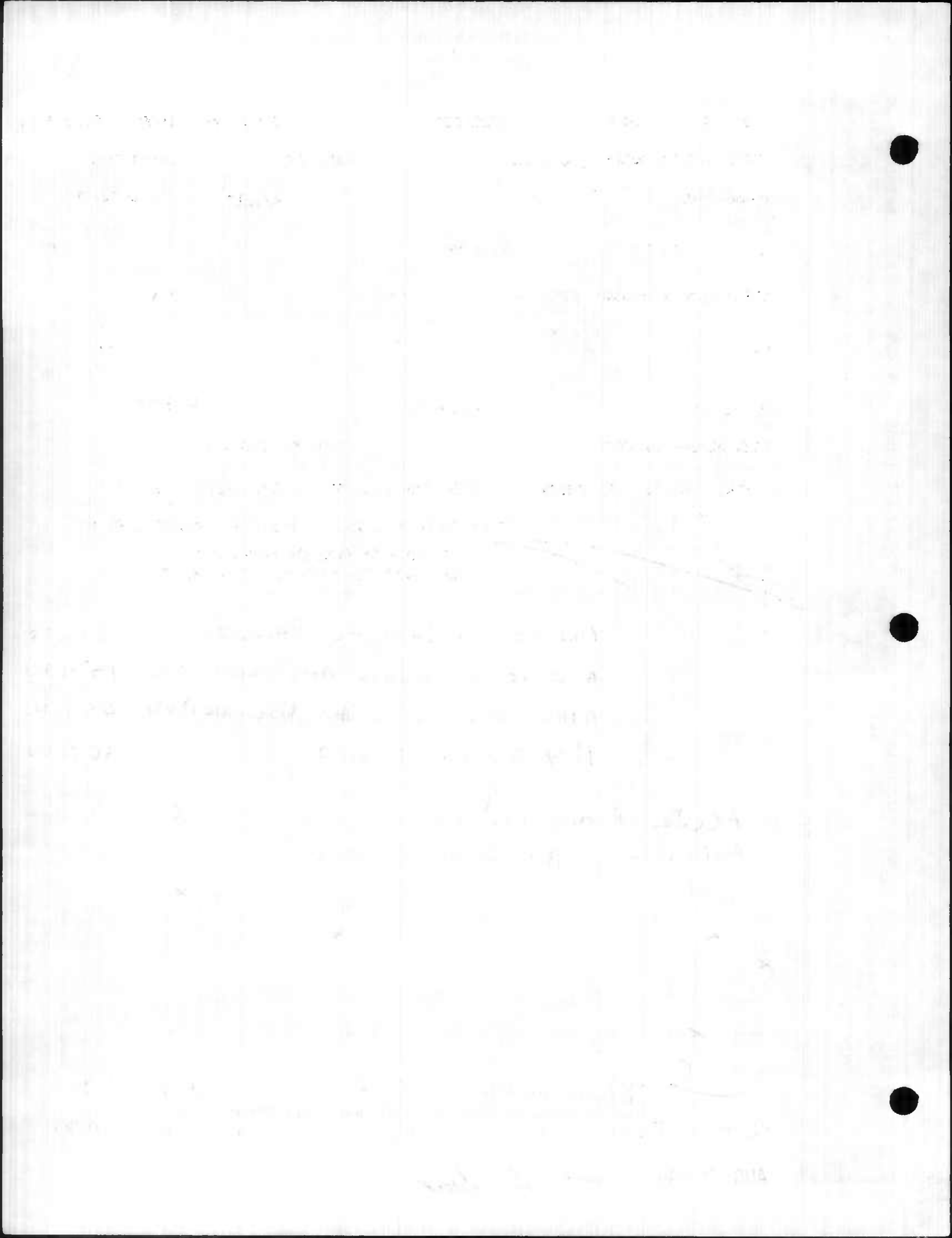
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) HELEN ANNE GREGLOIT | | 2. Date of Death Month Day Year JULY 29 1999 | | 3. Time of Death 8:30 P.M. | |
| 4a. Facility Name (If not institution, give street and number) GLEN MEADOWS NURSING CENTER | | | 4b. City, Town, or Location of Death GLEN ARM | | 4c. County of Death BALTIMORE |
| 5. Social Security Number 216-66-5610 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 | 8. Date of Birth (Month, Day, Year) 4/4/10 | 9. Birthplace (State or Foreign Country) MARYLAND |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location GLEN ARM | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 11630 GLEN ARM ROAD APT. G-15 | | | 10f. Zip Code 21057 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME |
| 17. Father's Name (First, Middle, Last) JOHN ALBERT FISCHER | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNE K. SEILAND | | |
| 19a. Informant's Name/Relationship (Type, Print) D. ELAINE NEWTON DAUGHTER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2270 TULSA AVENUE CLAREMONT, CA 91711 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC. | | 20c. Location - City or Town, State 7/30/99 CATONSVILLE, MD | |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE CARDIAC FAILURE Due to (or as a consequence of): b. AORTIC STENOSIS AND REGURGITATION Due to (or as a consequence of): c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): d. HYPERLIPIDEMIA | | | | | Approximate Interval Between Onset and Death 3 weeks 15 YEARS 45 YEARS 50 YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure Anemia. MAJOR DEPRESSION WOPD | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier R. GUPTA MD | | 29c. License number D 51228 | | 29d. Date signed (Month, Day, Year) 7/30/1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAMANA GOPALAN MD 2 EAST ROLLING CROSSROADS #159 BALTIMORE MD 21228 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature B. Sparks | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24122

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DELBERT L. HINKLE | | | | 2. Date of Death Month Day Year AUGUST 1, 1999 | | 3. Time of Death 9:10 P.M. | |
| | 4a. Facility Name (If not Institution, give street and number) 302 NURSERY RD. | | | | 4b. City, Town, or Location of Death LINTHICUM | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 235-44-9421 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 23, 1932 | |
| | 9. Birthplace (State or Foreign Country) WEST VIRGINIA | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location LINTHICUM | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 302 NURSERY RD. | | 10f. Zip Code 21090 | | 10g. Citizen of What Country? UNITED STATES | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST | | 16b. Kind of Business/Industry REFINERY | | | |
| | 17. Father's Name (First, Middle, Last) WILLIAM HINKLE | | | | 18. Mother's Name (First, Middle, Maiden Surname) LUCY MEADOWS | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) JUNE L. HINKLE / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 NURSERY RD., LINTHICUM, MARYLAND 21090 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEM. PK. | | 20c. Location - City or Town, State ELKRIDGE, MARYLAND | | 20d. Date AUGUST 4, 1999 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Gallbladder Cancer</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 3 months | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D 58137 | | 29d. Date signed (Month, Day, Year) AUGUST 2, 1999 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed causa of death (from 23e) (Type, Print) PETER P. RAMIREZ, M.D., 7845 OAKWOOD RD., SUITE 201, GLEN BURNIE, MD 21061 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24123

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clara Hensler

2. Date of Death

Month Day Year
July 31, 1999

3. Time of Death

11:00am

4a. Facility Name (If not institution, give street and number)

640 Stamford Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

212-05-6202

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 5, 1908

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

640 Stamford Road

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Keypuncher

16b. Kind of Business/Industry

Balto. Gas & Electric

17. Father's Name (First, Middle, Last)

William A. Lehnert

18. Mother's Name (First, Middle, Maiden Surname)

Jane Nice

19a. Informant's Name/Relationship (Type, Print)

Dorothy L. Wolf (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2725 Ansley Drive, Finksburg, MD 21048

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Entombment Lorraine Park Mausoleum

Date

8/3/99

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

Robert L. Bueh

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Aortic Stenosis
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

6 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Jeffrey F. Coleman

29c. License number

D 21512

29d. Date signed (Month, Day, Year)

8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey F. Coleman

3449 Wilkens Ave Balt, Md 21239

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24124

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Cornelia D. Hoffman | | | | 2. Date of Death Month Day Year AUGUST, 1, 1999 | | | | 3. Time of Death 1:40 PM | |
| | 4a. Facility Name (If not institution, give street and number) 4411 Adelle Terrace | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 216-32-7088 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 21, 1904 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 4411 Adelle Terrace | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | |
| | 17. Father's Name (First, Middle, Last) William C. Zies | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Richwien | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Ruth H. Hoffman (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4411 Adelle Terrace, Baltimore, Maryland 21229 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | Date 8/6/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee ▶ <i>Hande L. Lemmer</i> | | | | 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> <u>SEVERAL YEARS</u></p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | <u>INFECTED SACRAL AND SCAPULAR DECUBITUS</u> <u>ULCERS.</u> <u>END STAGE RHEUMATOID ARTHRITIS.</u> <u>CHRONIC ATRIAL FIBRILLATION.</u> | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier ▶ <i>Komal K. Dang M.D.</i> | | | | 29c. License number D-18362 | | 29d. Date signed (Month, Day, Year) 8-2-1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOMAL K. DANG M.D., 3455, WILKENS AVE, Suite 308, Balto. Md -21229 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24125

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT HUTCHINSON

2. Date of Death

Month

Day

Year

07/19/99

3. Time of Death

5:22 AM

4a. Facility Name (If not institution, give street and number)

Maryland Transient Care; Infirmary.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NA

Funeral
Director

5. Social Security Number

215-86-0017

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month

Day

Year

6/22/62

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

904 W. Lexington Street Apt. #14

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

College (1-4 or 5+)

NA

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

various trades

17. Father's Name (First, Middle, Last)

Herbert

Harvey

18. Mother's Name (First, Middle, Maiden Surname)

Mary

L.

Hutchinson

19e. Informant's Name/Relationship (Type, Print)

Mary L. Gee

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Ashlar Hill Court Baltimore, Maryland 21234

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Kings Mem. PK. Cem.

Date

07-29-99

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee

Doris M. Harris

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Chronic Liver Disease with Coagulopathy

Due to (or as a consequence of):

b.

Chronic Hepatitis B

Due to (or as a consequence of):

c.

AIDS

Due to (or as a consequence of):

d.

Pancytopenia

1991

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorder

Chronic Renal Failure

Peptic Ulcer Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Correction

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Aubersie

29c. License number

D-46597

29d. Date signed (Month, Day, Year)

7/19/99

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

TEDLA ANBESSÉ, MD; Maryland Transient Care

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

JAD

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, II, 27 PER MEO G774 8-4-99 WR

Reginald B. Harlee

Certificate of Death

Reg. No. 99 24126

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

716

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24 127

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie Jackson

2. Date of Death

July 30 99

3. Time of Death

1:45pm

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

202-14-6439

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 29, 1924

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1103 S. ELLWOOD AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

RUSSELL HOLT

18. Mother's Name (First, Middle, Maiden Surname)

RUBY GLOTFELTY

19a. Informant's Name/Relationship (Type, Print)

LARRY JACKSON - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1604 SHIRLEY AVENUE JOPPA, MARYLAND 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

OAK LAWN CEMETERY 8/2/99

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Elizabeth Selinski

22. Name and Address of Facility

CHARLES S. ZELLER & SON, INC.

6224 EASTERN AVENUE BALTIMORE, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Uro sepsis

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 days

Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. (R) Renal Calculi

Due to (or as a consequence of):

2 months

c. Bone Marrow Failure

Due to (or as a consequence of):

2 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William W. Roberts MD

29c. License number

N7344

29d. Date signed (Month, Day, Year)

July 30, 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William W. Roberts MD

Johns Hopkins Hospital Bayview

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

B. Sparks

State
Registrar

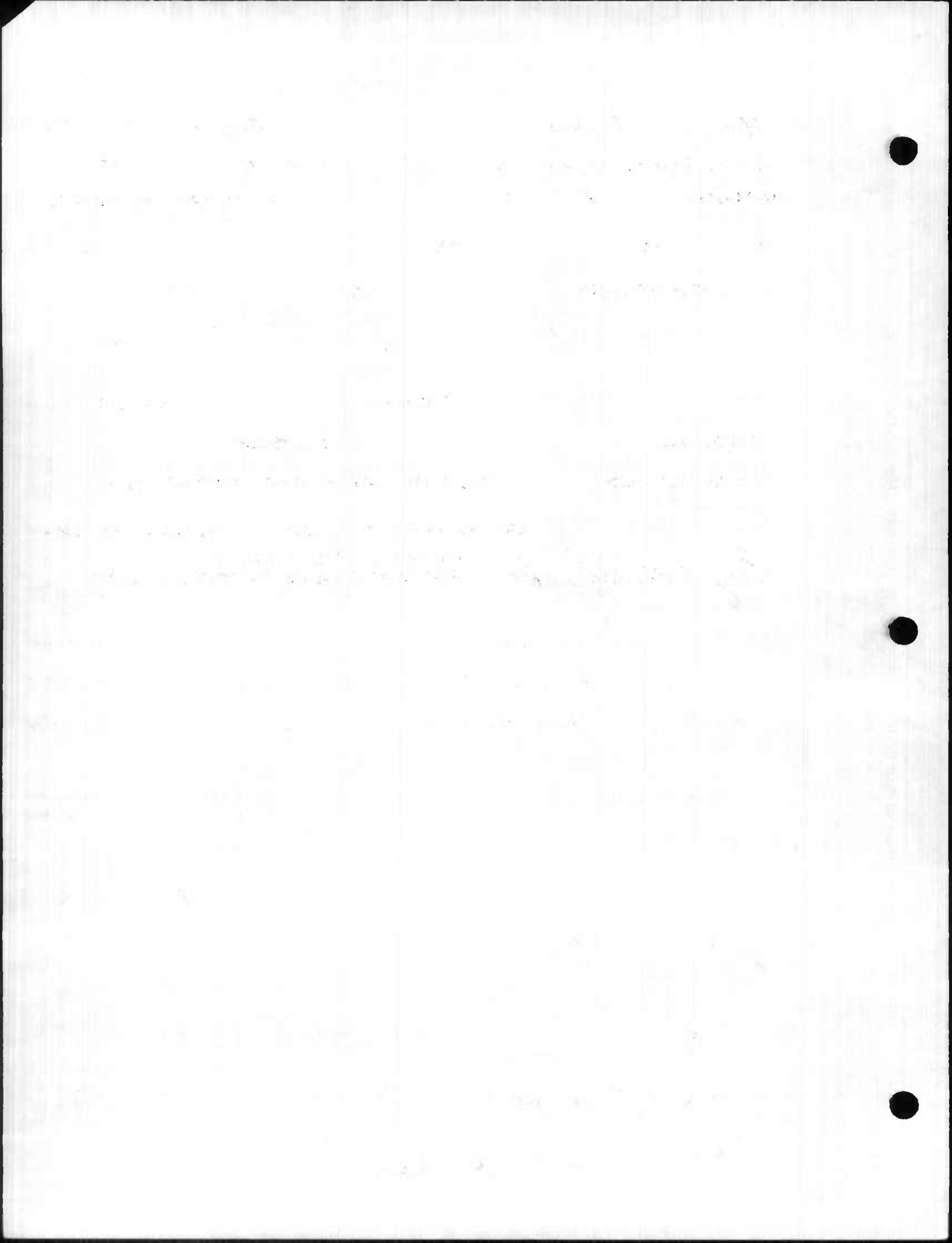
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH E. JONES

2. Date of Death

JULY 30, 1999

3. Time of Death

1:50 AM

4e. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-14-0969

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

7/11/05

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

LUTHERVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

311 EAST RIDGELY ROAD

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

CHARLES I. MCCLAIN

18. Mother's Name (First, Middle, Maiden Surname)

MARY E. ANZEL

19a. Informant's Name/Relationship (Type, Print)

LOIS BOTELER DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8727 LACKAWANNA AVENUE BALTIMORE, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY MEM. GAR.

Date

8/2/99

20c. Location - City or Town, State

COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/30/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

State
Registrar

ELIZABETH JONES July 30, 1999 1:50 a.m.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AHS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24 129

AMEND ITEM: #7 PER F.H. G774 8/2/99 WR.

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Michael N. Johnson | | | | 2. Date of Death Month: July Day: 28 Year: 99 | | 3. Time of Death 8:13am | |
| | 4e. Facility Name (If not institution, give street and number) 1915 E. LaFayette Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 220-64-5593 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 4241 Yrs. | If Under 1 Year Months: Days: | If Under 24 Hrs. Hours: Min. | 8. Date of Birth (Month, Day, Year) 09-04-57 | | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County NA | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 1915 E. LaFayette Avenue | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Longshorman | | | |
| | 17. Father's Name (First, Middle, Last) Norman T. Johnson | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna Knight | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Norman & Edna Johnson | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1915 E. LaFayette Avenue Baltimore, MD. | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Cem. | | Date 08-02-99 | 20c. Location - City or Town, State Arbutus, MD | | |
| | 21. Signature of Funeral Service Licensee Bernard D. Johnson | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alcoholic Hepatitis Due to (or as a consequence of): b. Alcohol Abuse Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Norman D. Anderson MD | | 29c. License number D16101 | | 29d. Date signed (Month, Day, Year) 7-30-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Norman D. Anderson Johns Hopkins Hospital Baltimore MD 21203 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

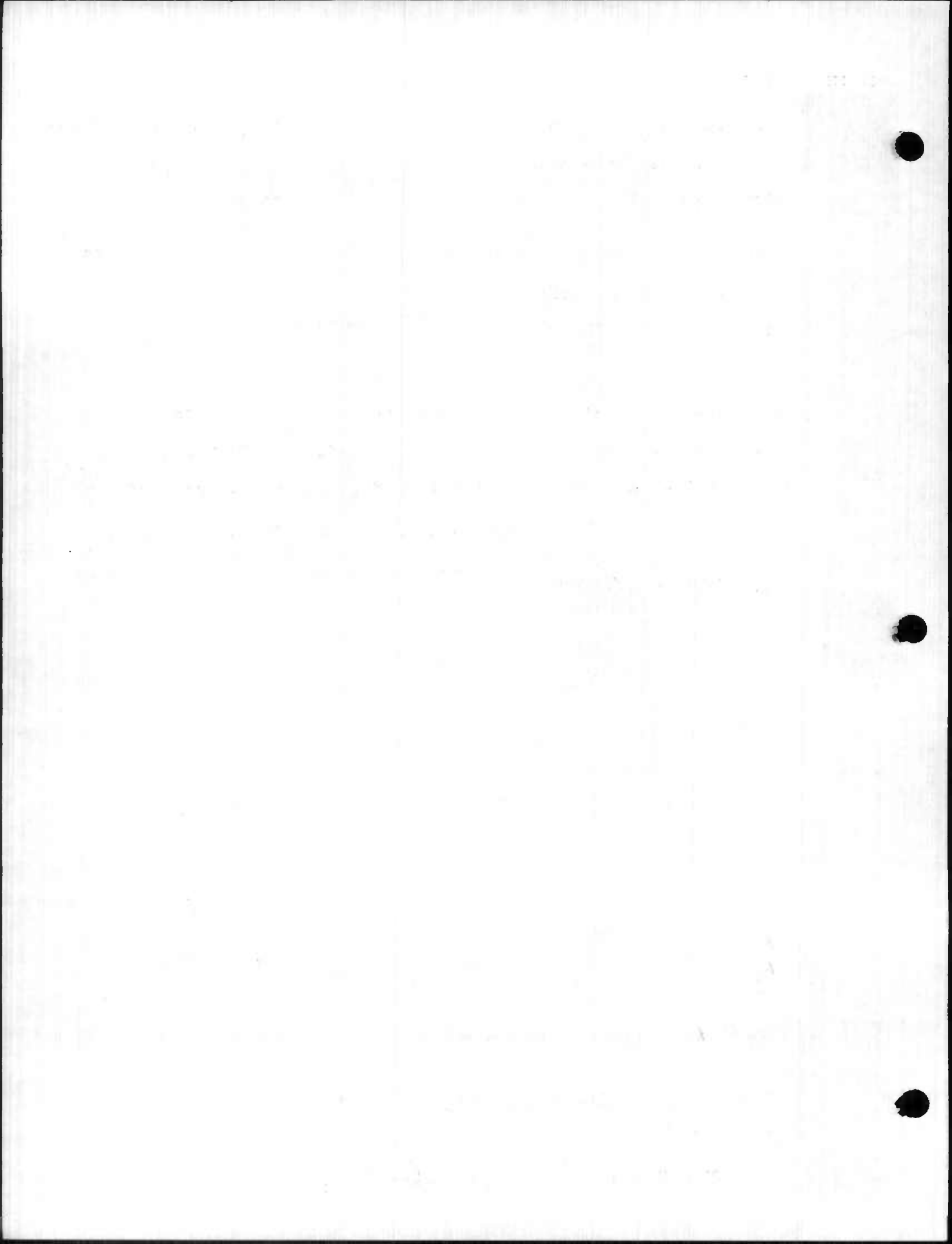
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24130

| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mendell Jones | | | | 2. Date of Death Month Day Year JULY 26, 1999 | | 3. Time of Death 0550 AM | |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL E.R. | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 219-98-8444 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 17 Yrs. | | 8. Date of Birth (Month, Day, Year) June 1, 1982 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County NA | |
| To Be Completed by Funeral Director | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5424 Nelson Ave. | |
| | 10f. Zip Code 21215 | | | | 10g. Citizen of What Country? USA | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| To Be Completed by Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+) 6 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT | | 16b. Kind of Business/Industry SCHOOL | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Lawrence M. Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marlene Smith | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Kay F. Ferrell Grandmother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5424 Nelson Ave Baltimore, MD 21215 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Doshell Cemetery | | 20c. Location - City or Town, State 8/2/99 Dundalk, MD | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Albert P. Wyllie Funeral Home PA 638 N. Gilman ST. Baltimore, MD 21217 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gunshot Wound to Chest | | | | | | | Approximate interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) 7/26/99 | | | | 28b. Time of Injury 0516 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred Subject Shot | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) Street; Founel - Parking lot of 200 South Spring Ct. Baltimore, Md. | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29d. Data signed (Month, Day, Year) JULY 27, 1999 |
| | 29b. Signature and title of certifier | | | | | | | |
| State Registrar | 29c. License number O.C.M.E | | | | | | | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 |
| | 31. Date filed (Month, Day, Year) AUG 2 1999 | | | | | | | |
| 32. Registrar's Signature | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24131

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

GEORGIA

E

JORDAN

2. Date of Death

Month
JULYDay
29Year
1999

3. Time of Death

0930 AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number

501-30-1413

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 30, 1934

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2226 Wonderview Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4or 5+)
0416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Buchanan

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Iverson

19a. Informant's Name/Relationship (Type, Print)

Henry Jordan/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2226 Wonderview Road, Timonium, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest Cemetery

Date

8/2/99

20c. Location - City or Town, State

Garrison, Maryland

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Road, Timonium, MD 21093

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

NON HODGKINS LYMPHOMA

Approximate
Interval Between
Onset and Death

1 YEAR

Due to (or as a consequence of):

b. PLEURAL EFFUSION DUE TO LYMPHOMA

2 WEEKS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Saad Akhtar M.D. SYED SAAD AKHTAR, MD D 0043489

29c. License number

29d. Date signed (Month, Day, Year)

JULY 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED SAAD AKHTAR, M.D. 600 North Wolfe St., Baltimore, MD 21287

31. Date filed (Month, Day, Year)

AUG 1 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMENDED ITEM #5 PER FH G774 8/2/99 AH

99 24132

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte R. King

2. Date of Death

Month Day Year
July 29 1999

3. Time of Death

2:10 AM

4a. Facility Name (If not institution, give street and number)

Mercy Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-80-9424

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Jan 28 1959

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
MD10b. County
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5710 Loch Raven Blvd Apt. C

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Investigator

16b. Kind of Business/Industry

Office

17. Father's Name (First, Middle, Last)

William King Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Harris

19a. Informant's Name/Relationship (Type, Print)

Sharetta King

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5710 Loch Raven Blvd Apt. C Balto, MD 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

8-4-99

20c. Location - City or Town, State

Randallstown, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gory P. March Funeral Home P.A.
270 Fredrickson Pass Balto, MD 21220

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D40854

29d. Date signed (Month, Day, Year)

July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG, 301 ST PAUL PI, BALTIMORE, MD 21202

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#1 perPhyG774 8/26/99 EW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN V. KING Evelyn Virginia King

2. Date of Death

07 10 99 09:27

3. Time of Death

09:27

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE

4b. City, Town, or Location of Death

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-18-8467

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 30, 1918 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1100 Luther Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0-12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

sales

16b. Kind of Business/Industry

retail

17. Father's Name (First, Middle, Last)

Clarence Russell Summers

18. Mother's Name (First, Middle, Maiden Surname)

Julia Ellen Groff

19a. Informant's Name/Relationship (Type, Print)

Mr. Richard Price/son-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

453 Laidig Road, Harrisonville, Pennsylvania 17228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rest Haven Cemetery

Date

July 14,
1999

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Minnich

22. Name and Address of Facility

Minnich Funeral Home

415 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Multisystem Organ Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Complications of Myocardial Infarction

Due to (or as a consequence of):

5 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bret D. Borcheit MD

29c. License number

D44498

29d. Date signed (Month, Day, Year)

7/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRET D. BORCHEIT, MD 22 S. GREENE ST BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

JUL 13 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Lillian H. Lese
2. Date of Death Month June Day 12, Year 1999
3. Time of Death 6 AM.

Funeral
Director

4a. Facility Name (If not institution, give street and number) Maple Ridge Home.
4b. City, Town, or Location of Death Rockville
4c. County of Death Montgomery
5. Social Security Number 579-09-1434
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 86 Yrs.
8. Date of Birth (Month, Day, Year) March 20, 13
9. Birthplace (State or Foreign Country) New York

Usual Residence of Decedent
10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Rockville 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 15908 Maple Ridge Court 10f. Zip Code 20853 10g. Citizen of What Country? United States

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant 16b. Kind of Business/Industry US Government

17. Father's Name (First, Middle, Last) Emmanuel Hertz 18. Mother's Name (First, Middle, Maiden Surname) Blanche Rosenthal

19a. Informant's Name/Relationship (Type, Print) Lawrence Lese/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 16012 Chester Mill Tr. Silver Spring, MD.

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Adas Israel Cong. Cem 6/14
20c. Location - City or Town, State Washington, DC.

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility Takoma Funeral Home. 254 Carroll St. NW Washington, DC. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. Artherosclerotic Heart Disease Years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Group Home.

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier [Signature] 29c. License number D33357 29d. Date signed (Month, Day, Year) 8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #1045 Dr. Lee Jonathan Musher, MD. 5530 Wisconsin Ave. Chevy Chase, MD.

31. Date filed (Month, Day, Year) AUG 2 1999 32. Registrar's Signature [Signature]

State
Registrar

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Sept 2 1961

Sept 2 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24135

| | | | | | | | | |
|---|--|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES MADISON MEBANE. JR. | | | | 2. Date of Death Month Day Year JULY 30, 1999 | | 3. Time of Death 4:15 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) BLUE POINT NURSING HOME | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212 07 0883A | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) MAR. 25, 1909 | |
| | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2321 HARLEM AVENUE | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? U.S. OF A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+) 4 YEARS | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAIL CARRIER | | 16b. Kind of Business/Industry U.S. POST OFFICE | | 17. Father's Name (First, Middle, Last) JAMES MADISON MEBANE, SR. | | |
| 18. Mother's Name (First, Middle, Maiden Surname) ELLA BLANCH STATEN | | 19a. Informant's Name/Relationship (Type, Print) JAMES M. MEBANE, III SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2321 HARLEM AVENUE BALTIMORE. MD. 21216 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEM. PARK | | 20c. Date 8/3/99 | | 20d. Location - City or Town, State BALTO. Co. | | 21. Signature of Funeral Service Licensee <i>Lewis T. Gwynn</i> | | |
| 22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Kidney Carcinoma with lung metastasis | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Amatan H. Naeem MD. | | 29c. License number D 15503 | | 29d. Date signed (Month, Day, Year) Aug 2, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amatan H. Naeem MD, 501 Dolphin St, Balto MD 21217 | | 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten marks on the left margin, including a long vertical line and a small 'y'.

Handwritten text in the middle of the page, possibly a signature or a name.

Handwritten 'X' mark in the lower left area.

Small handwritten mark in the lower middle section.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24136

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francis G. Mazziott

2. Date of Death

JULY 29, 1999

3. Time of Death

6:37 PM

4a. Facility Name (If not Institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-34-3992

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01/13/1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2703 Hemlock Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1954-62

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

College

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Electrical Estimator

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

John F. Mazziott

18. Mother's Name (First, Middle, Maiden Surname)

Caroline Andreasik

19a. Informant's Name/Relationship (Type, Print)

Mary JoAnn Mazziott/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2703 Hemlock Avenue, Baltimore, Maryland 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

08/02/99 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Christina L. David

22. Name and Address of Facility

Leonard J. Ruck, Inc.
5305 Harford Road, Baltimore, Maryland 21214Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIAC FAILURE

Approximate Interval Between Onset and Death

3- DAYS

a. Due to (or as a consequence of):

MYOCARDIAL INFARCTION

5-6 DAYS

b. Due to (or as a consequence of):

ARTEROSCLEROTIC CORONARY ARTERY DISEASE

20 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

R. C. Stewart Finney

29c. License number

D38655

29d. Date signed (Month, Day, Year)

7/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. C. STEWART FINNEY M.D., 7505 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

R. C. Stewart Finney

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN

2. Date of Death

Month

Day

Year

JULY

28

1999

3. Time of Death

10.10 AM

4a. Facility Name (If not institution, give street and number)

LEVINDALE HEBREW HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-32-0454

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

JUNE 11, 1912

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6711 PARK HEIGHTS AVENUE #105

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REGISTERED NURSE

16b. Kind of Business/Industry

MEDICINE

17. Father's Name (First, Middle, Last)

BENJAMIN

18. Mother's Name (First, Middle, Maiden Surname)

MATCHAR

19. Informant's Name/Relationship (Type, Print)

WILLIAM MARK / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6711 PARK HEIGHTS AVE. #105 - BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON CHIZUK AMUNO

Date

7/30/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CANCER LEFT BREAST WITH BONY METASTASES

18 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ATTENDING

29c. License number

D25610

29d. Date signed (Month, Day, Year)

JULY. 28. 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SET HTWAR MD. LEVINDALE 2434 WEST BELVERDERE AVENUE BALTIMORE MD 21215

State
Registrar

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

S. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24138

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bonnie A. Meredith

2. Date of Death

July 25, 1999

3. Time of Death

10²⁶ AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

412-66-5172

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 4, 1942

9. Birthplace (State or Foreign Country)

GA

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10758 Evening Wind Court

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Veterinary Medicine

17. Father's Name (First, Middle, Last)

David Eldredge Starley

18. Mother's Name (First, Middle, Maiden Surname)

Ella Mae (Ussery)

19a. Informant's Name/Relationship (Type, Print)

William C. Meredith (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10758 Evening Wind Court, Columbia, MD 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Columbia Mem. Park

Date

July 28, 1999

20c. Location - City or Town, State

Clarksville, MD

21. Signature of Funeral Service Licensee

Robert Gregory Buhon

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Rd. Columbia, MD 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. PROBABLE VENTRICULAR ARRHYTHMIA

Due to (or as a consequence of):

c. CARDIOMYOPATHY OF UNCERTAIN ETIOLOGY

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

HYPERTENSION

OBESITY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Tarnes, M.D.

29c. License number

D16810

29d. Date signed (Month, Day, Year)

July 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Tarnes, M.D. 11085 Little Patuxent Pkwy Columbia, MD 21044

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

Dana S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

10-11-1911

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24139

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Penelope Sara Martin

2. Date of Death

Month
July 29,Day
1999

Year

3. Time of Death

5:18 am

4a. Facility Name (If not institution, give street and number)

6308 Burnt Mountain Path

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

282-50-4067

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 20, 1953

9. Birthplace (State or Foreign Country)

MA

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6308 Burnt Mountain Path

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Technical Consultant

18b. Kind of Business/Industry

Hewlett

17. Father's Name (First, Middle, Last)

Harry Taylor Martin

18. Mother's Name (First, Middle, Maiden Surname)

Lydia Chenault

19a. Informant's Name/Relationship (Type, Print)

Candice Martin (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6308 Burnt Mountain Path, Columbia, Maryland 21045

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baltimore Washington Crem. 7/30/99 Laurel, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Road, Columbia, MD 2104523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Cardiopulmonary arrest

Due to (or as a consequence of):

b.

Metastatic breast cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

MD 41373

29d. Date signed (Month, Day, Year)

7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Said Baidas, M.D., 3800 Reservoir Road NW, Washington, D.C. 20007

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter. I am sorry that I cannot give you a more definite answer at this time, but I am sure that you will understand the necessity of this delay.

I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay.

I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay.

I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay.

I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay.

I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay. I am sure that you will understand the necessity of this delay.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24140

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH STOPFORD MURPHY

2. Date of Death

Month
JulyDay
30Year
1999

3. Time of Death

12:50 pm

4a. Facility Name (If not institution, give street and number)

CHARLESTOWN CARE CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

201-16-3554

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 20, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

709 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Spanish Teacher

16b. Kind of Business/Industry

High School Education

17. Father's Name (First, Middle, Last)

Ellis

Stopford

18. Mother's Name (First, Middle, Maiden Surname)

Martha

Leidy

19a. Informant's Name/Relationship (Type, Print)

Kathleen White (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2850 Pebble Beach Dr. Ellicott City, Md. 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

East Harrisburg Cem.

Date

8/3/99

20c. Location - City or Town, State

Harrisburg, Pennsylvania

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stallings Funeral Home P.A.

3111 Mountain Road Pasadena, MD. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D26473

29d. Date signed (Month, Day, Year)

July 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernard Koziovsky MD 711 Maiden Choice Lane, Catonsville, Md. 21228

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Name: RUTH MURPHY
Division of Vital Records, P.O. Box 68760,

1864

1864

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24141

| | | | | | | | | | | | |
|---|---|---|--|-------------------------------|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Moses McDaniel, Jr. | | | | | 2. Date of Death Month Day Year JULY 28, 1999 | | 3. Time of Death 04:39 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) JOHN HOPKINS BAYVIEW | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA | | | |
| Funeral Director | 5. Social Security Number 220-78-0741 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 27 Yrs. | | 8. Date of Birth (Month, Day, Year) 01-29-72 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 5010 Denview Way Apt. "C" | | | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High Sch. Grad | | College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician Apprentice | | | 16b. Kind of Business/Industry Free State Electric | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Moses McDaniel, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sharon Bowlding | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Sharon Bowlding | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5008 Denview Way Apt. "E" Baltimore, MD 21206 | | | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem. | | 20c. Location - City or Town, State 08-03-99 Owings Mills, MD | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Thermal Injury With Complications</u> Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | | |
| | b. _____ Due to (or as a consequence of): | | | | | | | | | | |
| | c. _____ Due to (or as a consequence of): | | | | | | | | | | |
| | d. _____ Due to (or as a consequence of): | | | | | | | | | | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7/20/99 | | 28b. Time of Injury 1826 M | | 28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred subject burned in electrical fire at work | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) workplace | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 300 West Lexington Street Baltimore, Maryland | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29c. License number OCME | |
| 29b. Signature and title of certifier | | | | | | | | | | 29d. Date signed (Month, Day, Year) JULY 29, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

JUL

1891

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24142

| | | | | | | | | | | | | | | | | |
|---|---|--|---|--|---|--|--------------------------------|--|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Dorothy Ann McCray</i> | | | | 2. Date of Death Month <i>July</i> Day <i>27</i> Year <i>1999</i> | | | | 3. Time of Death <i>01:21 AM</i> | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | | | 4c. County of Death | | | | | | | |
| Funeral Director | 5. Social Security Number <i>214-44-8322</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>57</i> Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) <i>3-31-1942</i> | | 9. Birthplace (State or Foreign Country) <i>Md</i> | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <i>Md</i> | | 10b. County <i>NA</i> | | 10c. City, Town or Location <i>Baltimore</i> | | | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number <i>5542 Nome Avenue</i> | | | | 10f. Zip Code <i>21215</i> | | | | 10g. Citizen of What Country? <i>U.S.A</i> | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>NA</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>House Keeping</i> | | | | 16b. Kind of Business/Industry <i>Hospital</i> | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <i>Eugene Crockett, Sr</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Hattie Veney</i> | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>Bernice Terry - Sister</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5224 Linden Heights Balto, Md 21215</i> | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Memorial Park</i> | | | | Date <i>8-2-99</i> | | 20c. Location - City or Town, State <i>Arbutus, Md</i> | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Gabrielle Cook</i> | | | | 22. Name and Address of Facility <i>Hardy E. H. West 4500 Wabash Avenue Balto, Md 21215</i> | | | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Immediate Cause (Final disease or condition resulting in death) e. <i>Adult Respiratory Distress Syndrome</i> Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <i>Acquired Immunodeficiency Syndrome</i> Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>A. Amanze / Resident</i> | | | | 29c. License number <i>RES-000</i> | | | | 29d. Date signed (Month, Day, Year) <i>July 27, 1999</i> | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Adanna Amanze 2401 W. Belvedere Ave. Baltimore, Md 21215</i> | | | | | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) <i>AUG 2 1999</i> | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24143

| | | | | | | | | |
|---|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward J. McDermott | | | | 2. Date of Death Month Day Year July 28, 1999 | | 3. Time of Death 5:28 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 212 32 6614 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 63 Yrs. | | 8. Date of Birth (Month, Day, Year) April 15, 1936 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Middle River | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 7346 Chesapeake Road | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1958-60 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Equipment Operator | | 16b. Kind of Business/Industry Construction | | | | |
| 17. Father's Name (First, Middle, Last) Edward Joseph McDermott | | | | 18. Mother's Name (First, Middle, Maiden Surname) Muriel Rappold | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jo Anne Kahler (cousin) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Bengies Road Middle River Maryland 21220 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gardens | | 20c. Date 7/30/99 | | 20d. Location - City or Town, State Baltimore Co., Md | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old eastern Avenue Essex, Maryland 21221 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) Pneumonia</p> <p>Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Emphysema</p> <p>Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death 7 Days</p> </div> </div> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Erik A. Eways | | | | 29c. License number 050228 | | 29d. Date signed (Month, Day, Year) July 28, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Erik Eways 9000 Franklin Square Drive Baltimore, MD 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

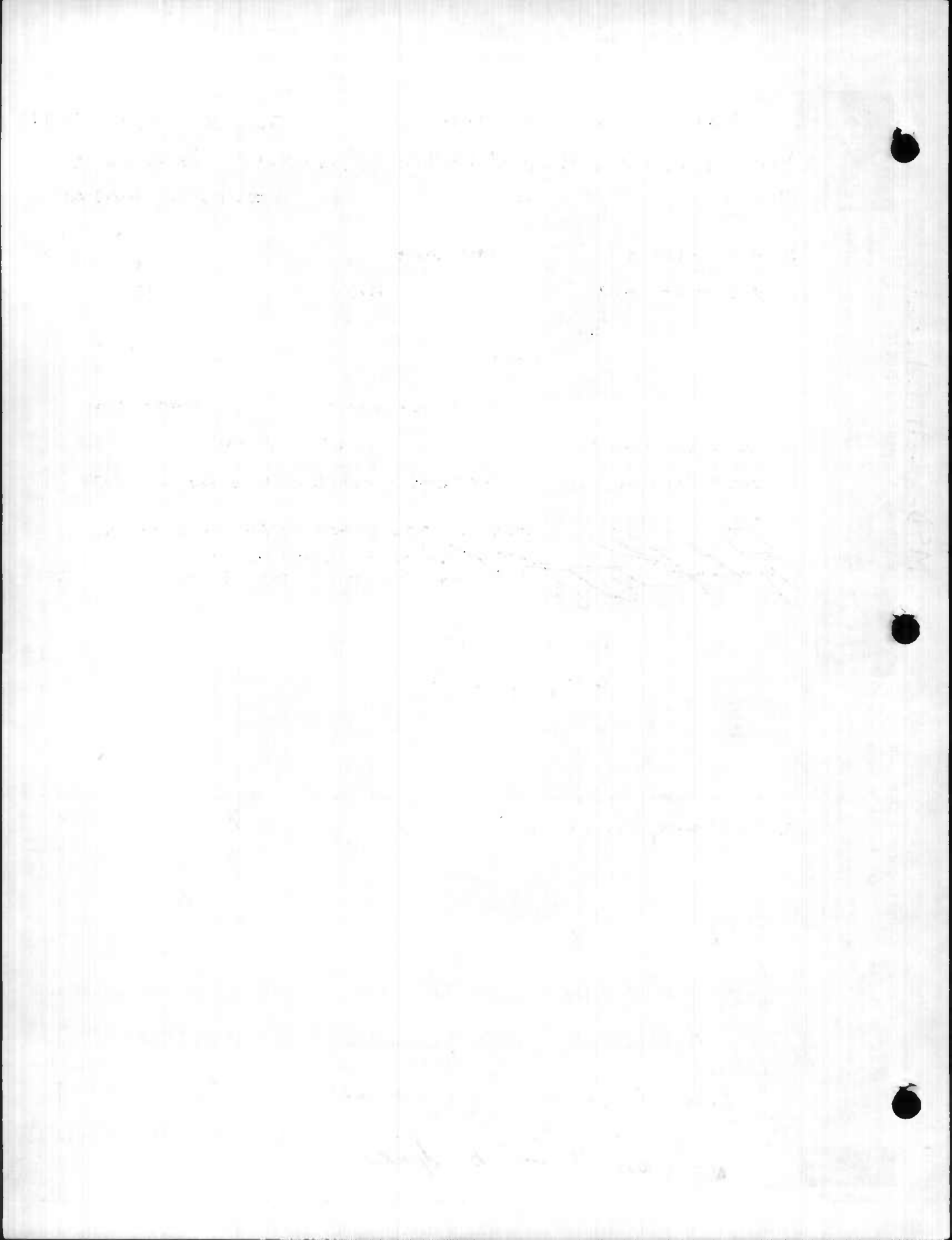
McDermott, Edward
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24144

Amended Item#1 perPhyG774 8/26/99 EW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA BEULAH VIRGINIA NIEDOMANSKI

2. Date of Death

Month JULY Day 18 Year 1999 10:15A.M.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

LORIE NURSING + REHABILITATION CTR

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NONE

5. Social Security Number

577-24-4565

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) March 19, 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State
Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4418 KAVON AVE.

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Clyde Fritter

18. Mother's Name (First, Middle, Maiden Surname)

Dollie Baker

19a. Informant's Name/Relationship (Type, Print)

Janet Niedomanski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chicamuxen United Methodist, Chicamuxen, Maryland

Date
July 21, 1999

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00668

22. Name and Address of Facility

Williams Funeral Home, P.A.
4270 Hawthorne Rd., Indian Head, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hemorrhage. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD

201-109 Back River Neck Rd Baltimore MD 21221

State
Registrar

31. Date filed (Month, Day, Year)

JUL 22 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. The first part of the report deals with the general conditions of the country during the year. It is found that the weather was generally favorable, and the crops were well grown. The stock raising industry was also successful, and the people were generally well satisfied with their condition.

2. The second part of the report deals with the financial condition of the country. It is found that the government was able to maintain its budget, and that the people were generally well satisfied with the financial condition of the country.

3. The third part of the report deals with the social conditions of the country. It is found that the people were generally well satisfied with their social conditions, and that the government was able to maintain its social policies.

4. The fourth part of the report deals with the educational conditions of the country. It is found that the government was able to maintain its educational policies, and that the people were generally well satisfied with the educational conditions of the country.

5. The fifth part of the report deals with the health conditions of the country. It is found that the government was able to maintain its health policies, and that the people were generally well satisfied with the health conditions of the country.

6. The sixth part of the report deals with the military conditions of the country. It is found that the government was able to maintain its military policies, and that the people were generally well satisfied with the military conditions of the country.

7. The seventh part of the report deals with the foreign relations of the country. It is found that the government was able to maintain its foreign relations, and that the people were generally well satisfied with the foreign relations of the country.

8. The eighth part of the report deals with the internal security of the country. It is found that the government was able to maintain its internal security, and that the people were generally well satisfied with the internal security of the country.

9. The ninth part of the report deals with the economic conditions of the country. It is found that the government was able to maintain its economic policies, and that the people were generally well satisfied with the economic conditions of the country.

10. The tenth part of the report deals with the cultural conditions of the country. It is found that the government was able to maintain its cultural policies, and that the people were generally well satisfied with the cultural conditions of the country.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24145

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|---|---|--|--|--|-----------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles John Pullara | | | | 2. Date of Death Month July Day 30 Year 1999 | | | | 3. Time of Death 3:45pm | |
| | 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 220-18-7573 | | 6. Sex 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) 01/05/1914 | | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3615 Brehms Lane | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) 8 Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Barber | | 16b. Kind of Business/Industry Self-employed | | | | | |
| | 17. Father's Name (First, Middle, Last) Ignatius Pullara | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carmela Bonica | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Charles R. Pullara/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8651 Hoerner Avenue, Baltimore, Maryland 21234 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns. | | Date 08/03/99 | | 20c. Location - City or Town, State Timonium, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Christina L. David Christina L. David | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ADULT RESPIRATORY DISTRESS SYNDROME 7 days PNEUMONIA 10 days | | | | | | | | Approximate Interval Between Onset and Death | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR ACCIDENT | | | | | | | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Veronica Epstein, MD | | 29c. License number P11852 AT 2438946 | | 29d. Date signed (Month, Day, Year) July 30, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VERONICA EPSTEIN UNION MEMORIAL HOSPITAL BACTO, MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

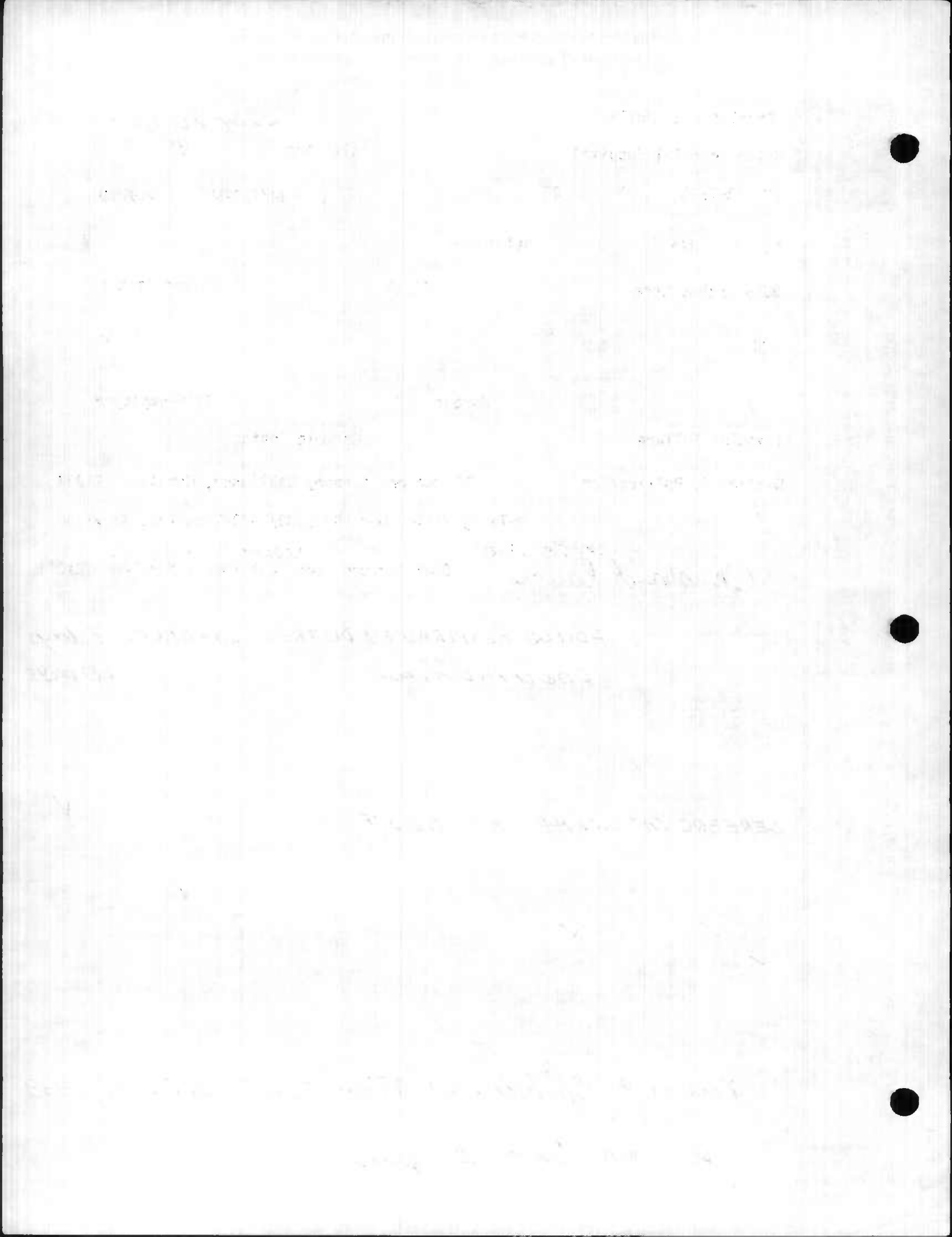
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6 AH

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24146

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Karen Rae Pinzuti

2. Date of Death

Month Day Year
July 30 1999

3. Time of Death

9:45PM

4a. Facility Name (If not institution, give street and number)

2733 Waldor Dr.

4b. City, Town, or Location of Death

Carney

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-40-4201

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 24, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Carney

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

2733 Waldor Drive

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward C. Vinroe

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Miller

19a. Informant's Name/Relationship (Type, Print)

Tonya Lurz / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2733 Waldor Drive Baltimore, MD 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gardens of Faith Cemetery 8/3/99

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Leonard J. Ruck, Inc. Funeral Home
5305 Harford Road Baltimore, Maryland23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic renal cell carcinoma

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)
728b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D36131

29d. Date signed (Month, Day, Year)

7/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Brave, M.D. St. Joseph's Medical Center 7620 York Road 21204

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24147

AMENDED ITEM #26 PER MD G774 8/2/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Willie, Edward, Pullen

2. Date of Death

Month Day Year
07 26 99

3. Time of Death

1211

4a. Facility Name (If not institution, give street and number)

Sinai Hosp.

4b. City, Town, or Location of Death

BALTO.

4c. County of Death

N.A.

Funeral
Director

5. Social Security Number

237-504078

6. Sex

M 20 F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 19, 1934

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State
md.

10b. County

N.A.

10c. City, Town or Location

BALTO.

10d. Inside City Limits

Yes 20 No

10e. Street and Number

4119 Fords Lane

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER-TRUCK DRIVER

16b. Kind of Business/Industry

TRUCKING CO.

17. Father's Name (First, Middle, Last)

SAMUEL PULLEN

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA CLANTON

19a. Informant's Name/Relationship (Type, Print)

MAMIE R. PULLEN/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4119 Fords Ln BALTO, md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBITUS Memorial Park

Date

7/30/99

20c. Location - City or Town, State

ARBITUS, Md.

21. Signature of Funeral Service Licensee

Patricia Betts

22. Name and Address of Facility

BETTS FUNERAL HOME
1129 N. Caroline St - BALTO, md. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. - Chronic Renal Failure

Due to (or as a consequence of):

b. - CAD

Due to (or as a consequence of):

c. - V.T.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen M. Pollock

29c. License number

D15236

29d. Date signed (Month, Day, Year)

7/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Pollock, Sinai Hospital

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

Beverly S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

per it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1897 10 24 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

99-4374-510
CJ
Unk. 99-165

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 99 24148

(MARK PRINGLE)

| | | | | | | | | |
|--|--|--|---------------------|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mark Andrew Pringle, Jr. | | | | 2. Date of Death Month Day Year July 25 1999 | | 3. Time of Death 08:45 AM. | |
| | 4a. Facility Name (If not institution, give street and number) 4900 Wetheredsville Road | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 217-23-8103 | | 6. Sex ♂ M 2 ☐ F | | 7. Age (In yrs. last birthday) 18 Yrs. | | 8. Date of Birth (Month, Day, Year) 07-06-81 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No | | 10e. Street and Number 3834 Cottage Avenue | | 10f. Zip Code 21215 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) G.E.D. NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping | | 16b. Kind of Business/Industry Private Industry | | |
| 17. Father's Name (First, Middle, Last) Mark Andrew Pringle, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Francine Bennett | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Baker | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 5204 Loch Raven Blvd. Apt. "B" Baltimore, Md | | | | |
| 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Kings Mem. Pk. Cem. | | 20c. Date 07-31-99 | | 20d. Location - City or Town, State Randallstown, MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. Multiple gunshot wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No | | |
| 25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No | | 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Scene | | | | | | |
| 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | 28a. Date of Injury (Month, Day, Year) UNK | | 28b. Time of Injury UNK M | | 28c. Injury at Work? 1 ☐ Yes 2 ☒ No | | |
| 28d. Describe how injury occurred Subject shot | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found in park | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4900 Blk Wetheredsville Rd. | | | | |
| 29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) July 26, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Locke, MD | | 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

A7-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24149

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Marie Puhl

2. Date of Death

Month
7

Day
26

Year
99

3. Time of Death

445 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

218-32-1952

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
April 22, 1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 Eastern Blvd.

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Corsitier

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Richard Caldwell

18. Mother's Name (First, Middle, Maiden Surname)

Mary (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Marion L. Ricketts

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

504 Meadow Road Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

7/31/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypotension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

20 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Savitha Shivananda MD

29c. License number

D 52379

29d. Date signed (Month, Day, Year)

July 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Savitha Shivananda MD 9000 Franklin Square Drive Baltimore Maryland 21237

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

[Signature] B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

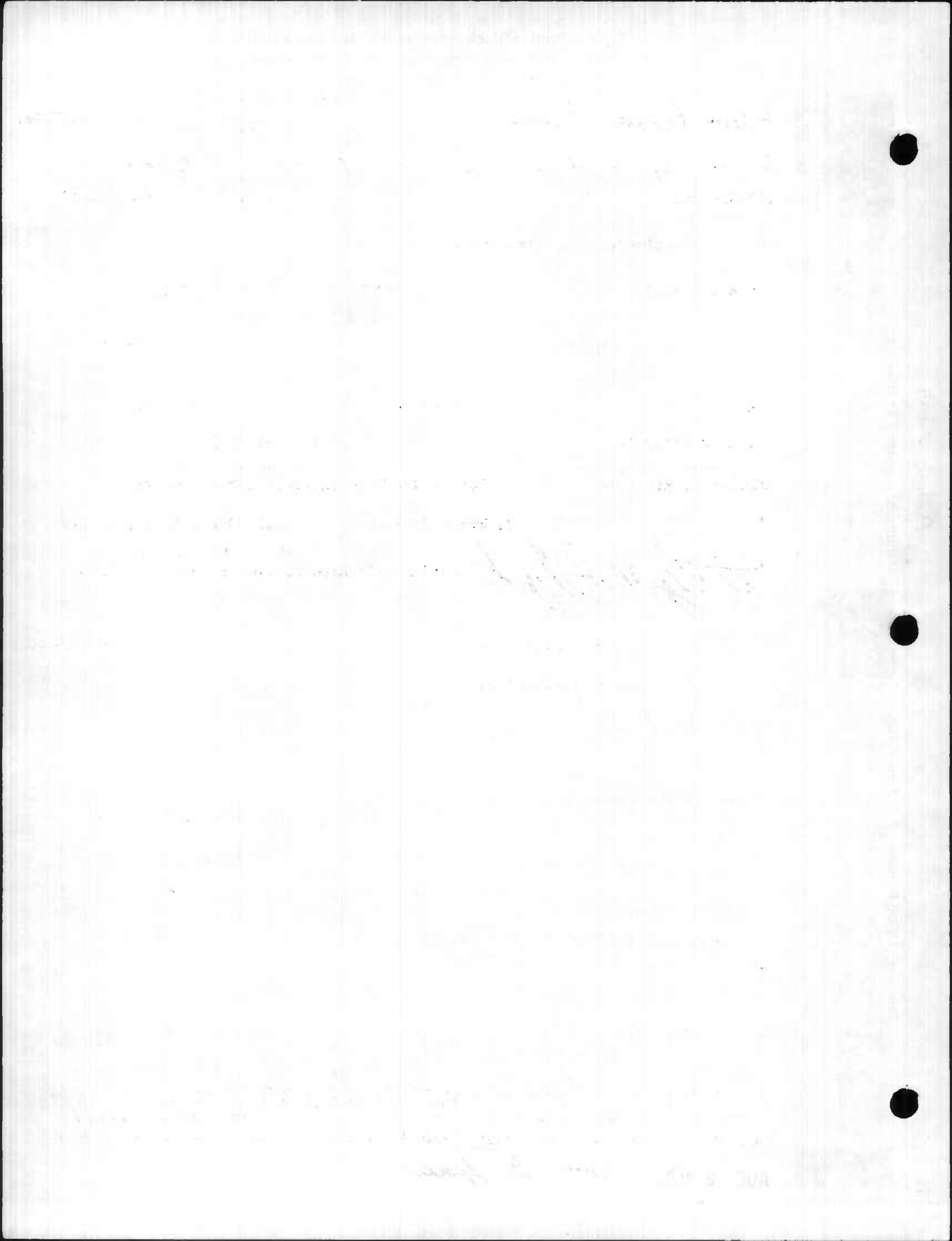
Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24150

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence L. Rose

2. Date of Death
Month Day Year

July 28 1999

3. Time of Death

10:02

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-36-9813

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

OCT. 30, 1907

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

FL

10b. County

DADE

10c. City, Town or Location

N. MIAMI BEACH

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2750 NE 183RD STREET #2601

10f. Zip Code

33160

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRIS

LEVETON

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

SMITH

19a. Informant's Name/Relationship (Type, Print)

EDWARD ROSE / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2329 VELVET RIDGE DRIVE - OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BALTIMORE HEBREW CEMETERY

Date

7/29/99

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. ISCHEMIC HEART DISEASE
Due to (or as a consequence of):c. DIABETES MELLITUS
Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

029085

29d. Date signed (Month, Day, Year)

JULY 28 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen J. Chincus 5310 Old Court Road 21133

State
Registrar

31. Date filled (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2025.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


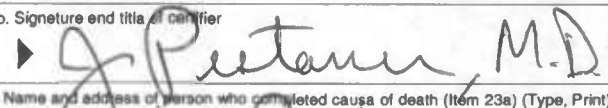
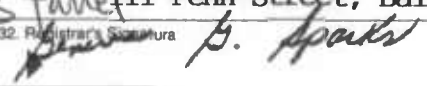
State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G774 8-3-99 WR.

Certificate of Death

Reg. No.

99 24151

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BRYAN ANGELO RANDALL | | | | 2. Date of Death Month Day Year JULY 26, 1999 | | 3. Time of Death 1003 AM | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 218-78-2607 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 37 Yrs. | | 8. Date of Birth (Month, Day, Year) 06 10 1962 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Maryland | | 10. City, Town or Location Baltimore City | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 3705 Woodridge Road | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (14 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance | | 16b. Kind of Business/Industry Mullen Enterprise | | | |
| | 17. Father's Name (First, Middle, Last) James Randall | | | | 18. Mother's Name (First, Middle, Maiden Summa) Delores Carter | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Delores Randall/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 Woodridge Road, Baltimore, Maryland 21229 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | Date 7/30/99 | | 20c. Location - City or Town, State Woodlawn, Maryland | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Maryland 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIAC HYPERTROPHY IN ASSOCIATION WITH ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 27, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner, 11 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 02 1999 | | | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

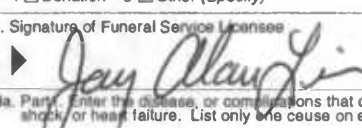
Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24152

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JACK SHOBIN | | 2. Date of Death Month JULY Day 28 Year 1999 | | 3. Time of Death 12.15 PM |
| | 4a. Facility Name (If not institution, give street and number) LEVINDALE HEBREW HOME | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 214-38-7593 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | Usual Residence of Decedent | | 8. Date of Birth (Month, Day, Year) JULY 26, 1907 | | 9. Birthplace (State or Foreign Country) LATVIA |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| 10e. Street and Number 2313 ROGENE DRIVE | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DENTIST | | 16b. Kind of Business/Industry DENTISTRY | |
| 17. Father's Name (First, Middle, Last) SHNAYNER | | 18. Mother's Name (First, Middle, Maiden Surname) ZALMAN NECHAMA BLOOM | | | |
| 19a. Informant's Name/Relationship (Type, Print) GERTRUDE SHOBIN / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2313 ROGENE DRIVE - BALTIMORE, MD 21209 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH EL MEMORIAL PARK | | 20c. Location - City or Town, State 7/30/99 RANDALLSTOWN, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 12 DAYS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE, HISTORY OF TRANSIENT ISCHEMIC ATTACK | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  ATTENDING PHYSICIAN | | 29c. License number D25610 | |
| | | 29d. Date signed (Month, Day, Year) JULY 28, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SET HTWAR M.D. LEVINDALE 2434 WEST BELVERDERE AVENUE BALTIMORE MD 21215 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24153

| | | | | | | | | | | | | |
|-------------------------------------|--|--|--|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Grace Carolyn Spadaro | | | | 2. Date of Death Month July Day 30, 1999 Year | | | | 3. Time of Death 11:55pm | | | |
| | 4a. Facility Name (If not Institution, give street and number) 716 Cypress Road | | | | 4b. City, Town, or Location of Death Severna Park | | | | 4c. County of Death Anne Arundel | | | |
| Funeral Director | 5. Social Security Number 214-24-5098 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 11, 1927 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 716 Cypress Road | | | | 10f. Zip Code 21146 | | | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 12th | | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | | 17. Father's Name (First, Middle, Last) Henry Stanley Chalmers | | | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Mariah Minnie Smith | | | | 19a. Informant's Name/Relationship (Type, Print) Joseph A. Spadaro/ Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Cypress Road Severna Park, Maryland 21146 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>Juanita R Thomas</i> | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. a. Metastatic Small Cell Lung Cancer Due to (or as a consequence of): b. Small Cell Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| Physician /Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>Charles McLucas</i> | | | | 29c. License number D31551 | | | |
| | 29d. Date signed (Month, Day, Year) August 2, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell A. McLucas 1600 S. Craig Highway Suite 603 Glen Burnie, MD 21061 | | | | 31. Date filed (Month, Day, Year) AUG 2 1999 | | | |
| | 32. Registrar's Signature <i>[Signature]</i> | | | | 33. State Registrar State Registrar | | | | 34. DHMH 16 Rev 6/95 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24154

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMORY WINFIELD SATTERFIELD

2. Date of Death

Month Day Year
JULY 29 1999

3. Time of Death

9:15 A.M.

4a. Facility Name (If not institution, give street and number)

1101 IVYWOOD LANE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-22-2058

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
6/27/34

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1101 IVYWOOD LANE APT. 201

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

INVENTORY CONTROL SUPERVISOR

16b. Kind of Business/Industry

HOWARD JOHNSON

17. Father's Name (First, Middle, Last)

EMORY WINFIELD SATTERFIELD

18. Mother's Name (First, Middle, Maiden Surname)

GERALDINE FRANCES COLE

19a. Informant's Name/Relationship (Type, Print)

PAUL W. SATTERFIELD, JR. SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 STABAME COURT BALTIMORE, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MORELAND MEMORIAL PARK

Date

8/2/99

20c. Location - City or Town, State

HILLENDALE, MD

21. Signature of Funeral Service Licensee

Heather N. Hays

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Brain Metastases*
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

4 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. *Small Cell Lung Cancer, Bone Met*
Due to (or as a consequence of):

1 yr

c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. A. Serpick MD

29c. License number

D10091

29d. Date signed (Month, Day, Year)

7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. M. A. Serpick MD

ST Joe Med Ctr

Towson MD 21204

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

*B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten text, possibly a signature or date, located in the center of the page.

Handwritten text at the bottom of the page, including what appears to be a date "Nov 12 1918" and a signature.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24155

| | | | | | | | | |
|--|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HENRIETTA DOLLY SPRINGER | | | | 2. Date of Death Month Day Year July 30 1999 | | 3. Time of Death 6:27 PM | |
| | 4a. Facility Name (If not institution, give street and number) Genesis Eldercare Caton manor | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 213-10-5245 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 96 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-14-1902 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10. Usual Residence of Decedent | | 10a. State MD | | 10b. County BALTIMORE | |
| 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1450 KIRKWOOD ROAD | | 10f. Zip Code 21207 | | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RECEPTIONIST | | 16b. Kind of Business/Industry STEWART COMPANY | | |
| 17. Father's Name (First, Middle, Last) JACK SPRINGER | | 18. Mother's Name (First, Middle, Maiden Surname) MARTHA (HICKMAN) | | 19a. Informant's Name/Relationship (Type, Print) DOROTHY KEMPLE (NIECE) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1450 KIRKWOOD ROAD BALTIMORE, MD 21207 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) LODGE PARK CEMETERY | | 20c. Date 8/2/99 | | 20d. Location - City or Town, State BALTIMORE, MD | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. myocardial infarction Due to (or as a consequence of): b. coronary artery disease Due to (or as a consequence of): c. atherosclerotic heart disease Due to (or as a consequence of): d. chronic alcohol | | Approximate Interval Between Onset and Death 1d 10yr 10yr <1yr | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier | | 29c. License number D 29769 | | 29d. Date signed (Month, Day, Year) 8/1/99 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W. D. Roberts MD 1120 W. Rolling Vol Bldg 4th | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | |

1880

to the
of the
the
the

the
the
the

the
the
the
the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24156

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|--|--|--|--|--|---|----|-------------------------|--------|----|------------------------|----------|----|--------------------------|---------|----|-----------------|---------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Catherine Sunderland | | | | 2. Date of Death Month Day Year August 1, 1999 | | 3. Time of Death 9:30PM | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Millennium Health | | | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death Anne Arundel | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 214-12-1844 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 20 1911 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 1232 Cleveland Street | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hat Company | | 16b. Kind of Business/Industry Retail Manufacturing | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Sam Venturalla | | | | 18. Mother's Name (First, Middle, Maiden Surname) Santa unknown | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Marie Noonan daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8472 Main Ave. Pasadena, Maryland 21122 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. | | Date 8/2/1999 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena, MD 21122 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Coronary Artery Disease</td> <td>1 year</td> </tr> <tr> <td>b.</td> <td>Essential Hypertension</td> <td>10 years</td> </tr> <tr> <td>c.</td> <td>Cerebrovascular Accident</td> <td>5 years</td> </tr> <tr> <td>d.</td> <td>Senile Dementia</td> <td>6 years</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Coronary Artery Disease | 1 year | b. | Essential Hypertension | 10 years | c. | Cerebrovascular Accident | 5 years | d. | Senile Dementia | 6 years |
| | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Coronary Artery Disease | 1 year | | | | | | | | | | | | | | | | | |
| b. | | Essential Hypertension | 10 years | | | | | | | | | | | | | | | | | | |
| c. | | Cerebrovascular Accident | 5 years | | | | | | | | | | | | | | | | | | |
| d. | | Senile Dementia | 6 years | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D14160 | | 29d. Date signed (Month, Day, Year) Aug. 2, 1999 | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit Singh, M.D., 5410-A Ritchie Highway Baltimore, Md. 21225 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24157

| | | | | | | | | | | | |
|--|---|---------------------------|--|---|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Andre Swann | | | | | | 2. Date of Death Month Day Year July 28, 1999 | | 3. Time of Death 1:11 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland, Shock Trauma | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 214-88-5545 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 37 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec 21, 1961 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10a. State MD | | 10b. County N/A | | 10e. Street and Number 849 West Lombard Street | | | | 10f. Zip Code 21201 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | | 16b. Kind of Business/Industry Department of Sanitation | | | |
| 17. Father's Name (First, Middle, Last) Clarence P. Swann | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margie Marie Sampson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Margie Gagum (Mother) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 849 West Lombard Street, Baltimore, MD 21201 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery | | | Date Aug 3 1999 | | 20c. Location - City or Town, State Baltimore., MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Debaord Gunshot Wound Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) 7/28/99 | | 28b. Time of Injury 1220 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject shot self | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At Home | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 849 W. Lombard St, 21201 | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 29, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 02 1999 | | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-685-2028.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24158

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLA

SANDERS

2. Date of Death

Month

Day

Year

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

228-38-7353

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

8. Date of Birth

Month

Day

Year

9. Birthplace (State or Foreign Country)

05-21-29

10. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

1046 Old North Point Road

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

St. David's

17. Father's Name (First, Middle, Last)

Guy Claiborne, Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Lula Belle Holmes

19a. Informant's Name/Relationship (Type, Print)

Diane Brock-Gerald

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26 Ashlar Hill Court Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem. 07-30-99 Owings Mills

Data

20c. Location - City or Town, State MD

21. Signature of Funeral Service Licensee

Bernard D. Johnson

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adult Respiratory Distress Syndrome

Due to (or as a consequence of):

2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

3 WEEKS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lupus

Interstitial Pulmonary Fibrosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Luis Diaz

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUIS DIAZ, MD

JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

State
Registrar

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

Luis Diaz

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

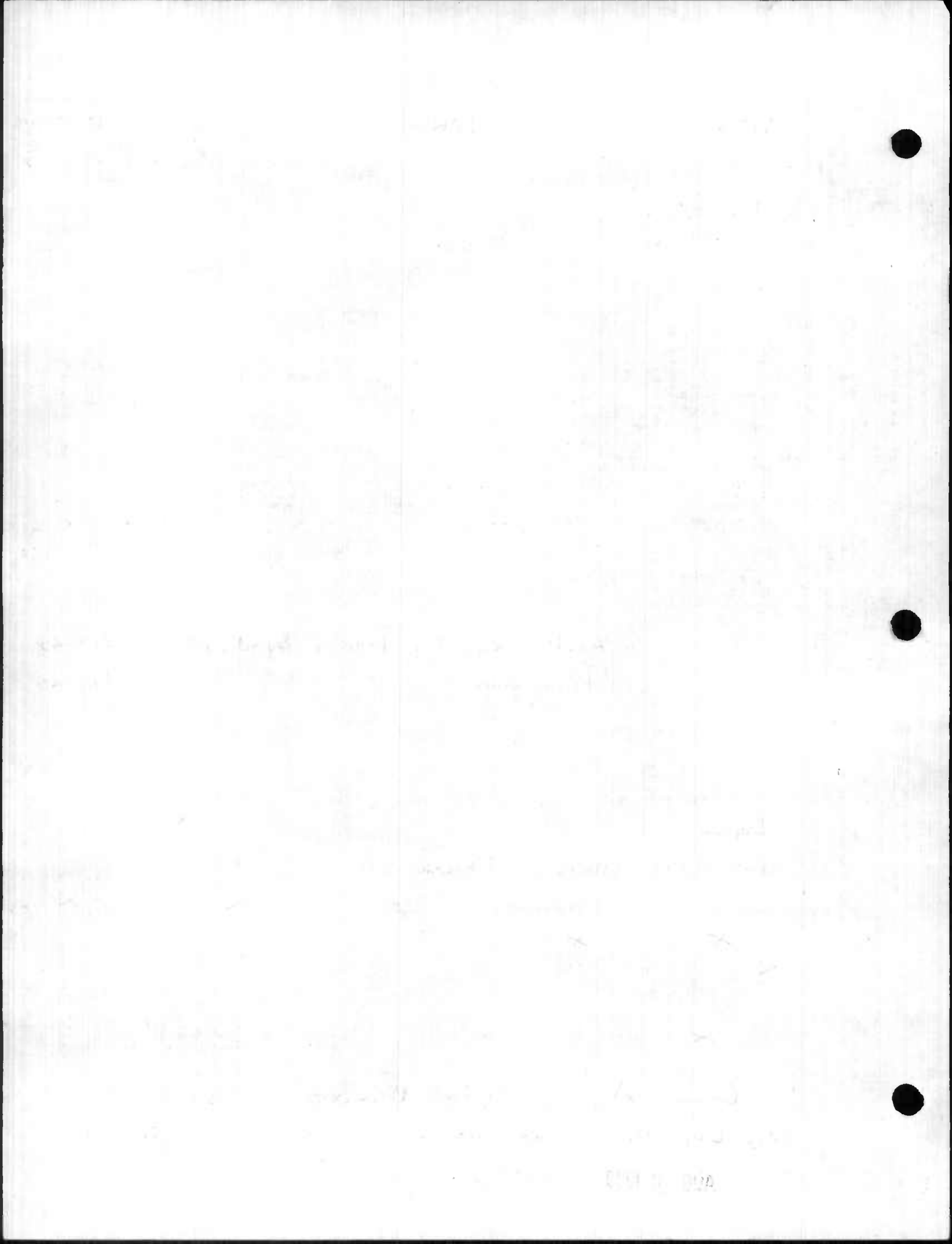
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23apt1 perPhyG774 8/2/99 EW

Certificate of Death

Reg. No. 99 24159

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRIETTE WOODWARD SHELTON

2. Date of Death

07 09 99

3. Time of Death

4:10AM

4a. Facility Name (If not Institution, give street and number)

Broadmeade

4b. City, Town, or Location of Death

Cockeysville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

149-01-4596

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 5, 1912

9. Birthplace (State or Foreign Country)

Mass.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13801 York Road

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Community College

17. Father's Name (First, Middle, Last)

Joseph Donald Woodward

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Breisch

19a. Informant's Name/Relationship (Type, Print)

Richard Shelton/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5715 Edmondson Ave. #AA7, Baltimore, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

SEPSIS 29 Bowel obstruction

a. ~~Multiple organ system failure~~

Due to (or as a consequence of):

b. ~~Failure to thrive~~ ASCVD

Due to (or as a consequence of):

c. CHF

Due to (or as a consequence of):

d. COPD

Approximate
Interval Between
Onset and Death

1 mo.

Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD

COPD

CHF

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
investigation
6 ☐ Could not be
determined28a. Date of injury
(Month, Day, Year)28b. Time of
injury

M

28c. Injury at
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

F. SANDAROD, BROADMEADE, 13801 YORK RD, COCKEYSVILLE MD 21030

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24160

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alexander Arthur Szymanski

2. Date of Death

Month JULY Day 26 Year 1999

3. Time of Death

1118 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-20-3972

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) July 11, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1734 Wycliffe Road

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Martin

17. Father's Name (First, Middle, Last)

Alex Szymanski

18. Mother's Name (First, Middle, Maiden Surname)

Michaline Ruszkiewicz

19a. Informant's Name/Relationship (Type, Print)

Dolores Szymanski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1734 Wycliffe Road Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Moreland Memorial Park

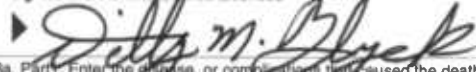
Date

7/30/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

CARDIO RESPIRATORY ARREST

2 MONTHS

e.

Due to (or as a consequence of):

ACUTE INTESTINAL ISCHEMIA

2 MONTHS

b.

Due to (or as a consequence of):

RUPTURED ABDOMINAL AORTIC ANEURYSM

2 MONTHS

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROTIC HEART DISEASE

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 29579

29d. Date signed (Month, Day, Year)

7/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM J. ROE M.D. 200 W. COLDSRING LANE BALTIMORE MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24161

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Teipe

2. Date of Death

Month
AugustDay
1Year
1999

3. Time of Death

8:15am

4e. Facility Name (If not institution, give street and number)

Catonsville Commons

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-05-8903

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
Aug. 4, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16 Fusting Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Order Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Emil Droll

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Gross

19e. Informant's Name/Relationship (Type, Print)

Carol Reilly, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 Old New England Road Stoney Creek, CT 06405

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

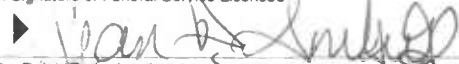
Date

8/5/99

20c. Location - City or Town, State

Woodlawn, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Ambrose Funeral Home, Inc.
1328 Sulphur Spring Road Arbutus, MD 21227

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Congestive heart Failure

Approximate Interval Between Onset and Death

1 week

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

Ischemic heart disease

several yrs.

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease
Bipolar Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

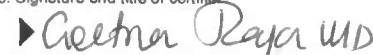
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

DA7541

29d. Date signed (Month, Day, Year)

August 2, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CIBETHA RAJA, 4367 HOLLINS PERRY RD, BALTIMORE, MD-21227

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24162

Amended Item#2 perPhyG774 8/2/99 EW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Thomas

2. Date of Death
Month Day Year7-20-99
3 6 19993. Time of Death
5:20 AMFuneral
Director

4a. Facility Name (If not institution, give street and number)

Pineview

4b. City, Town, or Location of Death

Clinton, MD

4c. County of Death

P.G.

5. Social Security Number

219-167781

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

03/06/1911

9. Birthplace (State or Foreign Country)

Va

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9106 Pineviewlane

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10th gradeCollege (1-4 or 5+)
NA16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farming

16b. Kind of Business/Industry

—

17. Father's Name (First, Middle, Last)

George Thomas, Sr

18. Mother's Name (First, Middle, Maiden Surname)

Mary Sayles

19a. Informant's Name/Relationship (Type, Print)

Clementine Moore (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3502 Eyre Drive South Upper Marlboro

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Memorial Park

Date

7-24-99 Randallstown, MD

21. Signature of Funeral Service Licensee

Jerome A. Thompson

22. Name and Address of Facility

March F.H. West
7300 Walden Avenue Baltimore23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Acute Myocardial Infarction

Due to (or as a consequence of):

b.

C.V.A.

Due to (or as a consequence of):

c.

P. Anterior Septal. Pericarditis

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

2 1/2 hours

2 gm

3 gm

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Michael Gobran

29c. License number

DKS 365

29d. Date signed (Month, Day, Year)

7-20-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Gobran Sidarous, Pineview Nursing Home

31. Date filed (Month, Day, Year)

JUL 29 1999

32. Registrar's Signature

B. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

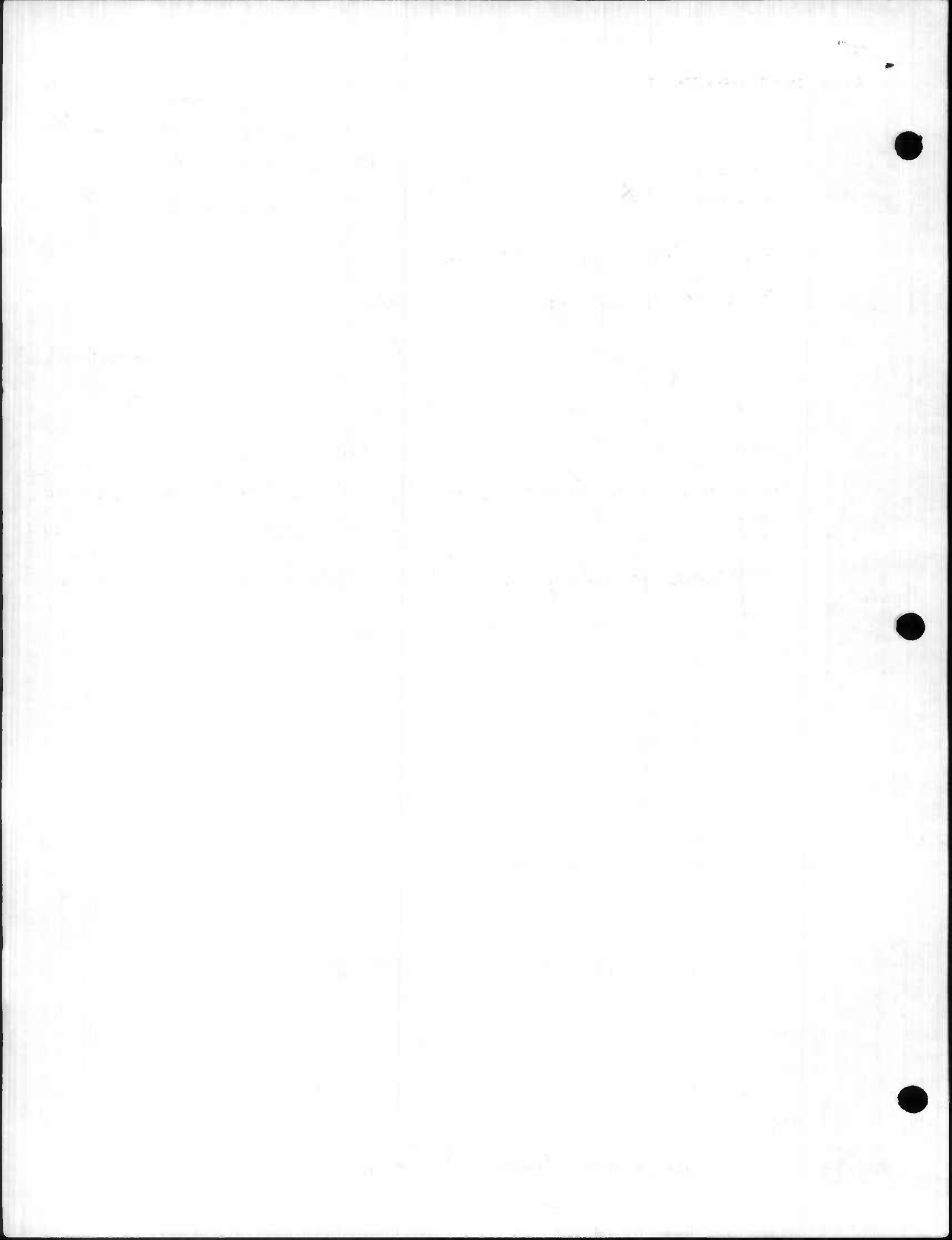
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24163

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SIMA VAYSTIKH | | | | 2. Date of Death Month Day Year JULY 29, 1999 | | 3. Time of Death 4:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 214-41-4921 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB. 3, 1924 | |
| | 9. Birthplace (State or Foreign Country) UKRAINE | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 4 AMLET COURT #2D | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? UKRAINE | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last) DAVID VAYSTIKH | | | | 18. Mother's Name (First, Middle, Maiden Surname) YENTA (UNKNOWN) | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) DIANA KOGAN / DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 SQUIRE COURT - REISTERSTOWN, MD 21136 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO | | 20c. Date 7/30/99 | | 20d. Location - City or Town, State BALTIMORE, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. MYOCARDIAL INFARCTION (PROBABLE) IMMEDIATE Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS RECENT CEREBRAL INFARCTION | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier <i>[Signature]</i> M.D. | | 29c. License number D15140 | | 29d. Date signed (Month, Day, Year) July 29, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IAN SUNSHINE MD 6210 PK.Hts. Ave, BALT, MD 21215 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#17,18 per Inf.G774 8/9/99 EW

Certificate of Death

Reg. No. 99 24164

| | | | | | | | | | | |
|---|---|--|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rose Ellen Williamson | | | | 2. Date of Death Month Day Year July 27, 1999 | | | | 3. Time of Death 10:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Rehabilitation Center | | | | 4b. City, Town, or Location of Death Ellicott City | | | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 213-34-9415 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) April 10, 1909 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 1324 Lafayette Avenue | | | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Domestic | | |
| | 17. Father's Name (First, Middle, Last) Francisco Martin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dora Luers | | | | | |
| To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (Type, Print) Rosemary O'Hara Brooks/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1324 Lafayette Ave. Baltimore, Maryland 21207 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery | | Date 7/30/99 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>David J. Weber</i> | | | | 22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 5611 Edmondson Ave. Baltimore, Maryland 21229 | | | | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <i>Myocardial Infarction</i> Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death <i>Immediate</i> | | | | | |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier <i>Patrick W. White M.D.</i> | | | | 29c. License number D23365 | | 29d. Date signed (Month, Day, Year) 7/28/99 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick W. White 716 Maiden Lane #205, Balt, MD 21228 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 2 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24165

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BEATRICE

2. Date of Death

Month Day Year 20:50
July 29 1999

3. Time of Death

WATCHMAN

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-18-7125

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2/15/1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4011 Fleetwood Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Drug Store

17. Father's Name (First, Middle, Last)

Benjamin Miller

18. Mother's Name (First, Middle, Maiden Summa)

Lottie Grace Taylor

19a. Informant's Name/Relationship (Type, Print)

Mark Rhoades/Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

738 Gullane Drive Charlesto SC. 29414

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

8/2/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

John C. Miller Inc.
6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PERFORATED PEPTIC ULCER DISEASE.

Approximate Interval Between Onset and Death

14 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

P12126

29d. Date signed (Month, Day, Year)

07/29/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALID ABOUJAOUDE 6920 DONACHIE RD #705 BALTIMORE MD 21239

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24166

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

HELEN MARTHA ZABLESKI

2. Date of Death

Month Day Year
July 29 1999

3. Time of Death

11:05 A.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-07-4283

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAR. 10, 1916

9. Birthplace (State or Foreign Country)

WASH. D.C.

Usual Residence of Decedent

10e. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

ROSEDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1315 CHESACO AVE. APT. #213

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8TH

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

STEPHEN REDA

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES JANKIEWICZ

19a. Informant's Name/Relationship (Type, Print)

JAMES ZABLESKI/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8907 TALC DR. APT 1B, BALTIMORE, MD. 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SACRED HEART OF JESUS

Date

8/2/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MORAN ASHTON DABROWSKI FUNERAL HOME
3000 E. BALTIMORE ST. BALTIMORE, MD.

23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RD 187252

29d. Date signed (Month, Day, Year)

July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Dawn Warner 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

AUG 2 1999

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician
(Medical
Examiner)To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24167

| | | | | | | | | | |
|--|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HAKIM ABDULLAH | | | | 2. Date of Death Month JULY Day 31 Year 1999 | | 3. Time of Death 01:37am | | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death NTA | | |
| Funeral Director | 5. Social Security Number 214-58-7785 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) OCT. 10, 1952 | 9. Birthplace (State or Foreign) Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 3403 Woodbrook Ave. | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Afro-American | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed | | 16b. Kind of Business/Industry N/A | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Walker Stone, Jr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Smith | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ms. Victoria Queen (Sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Jefferson St. Balto. Md. 21205 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion | | 20c. Location - City or Town, State 8/9/99 Lansdowne, Md. | | 21. Signature of Funeral Service Licensee Joseph L. Russ | | |
| | 22. Name and Address of Facility Joseph L. Russ Funeral Home | | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HYPERKALEMIA | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | Approximate Interval Between Onset and Death 5 hrs. | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE. | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Tariq Khan | | 29c. License number D0021730 | | 29d. Date signed (Month, Day, Year) JULY 31 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ KHAN SINAI HOSPITAL | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature [Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

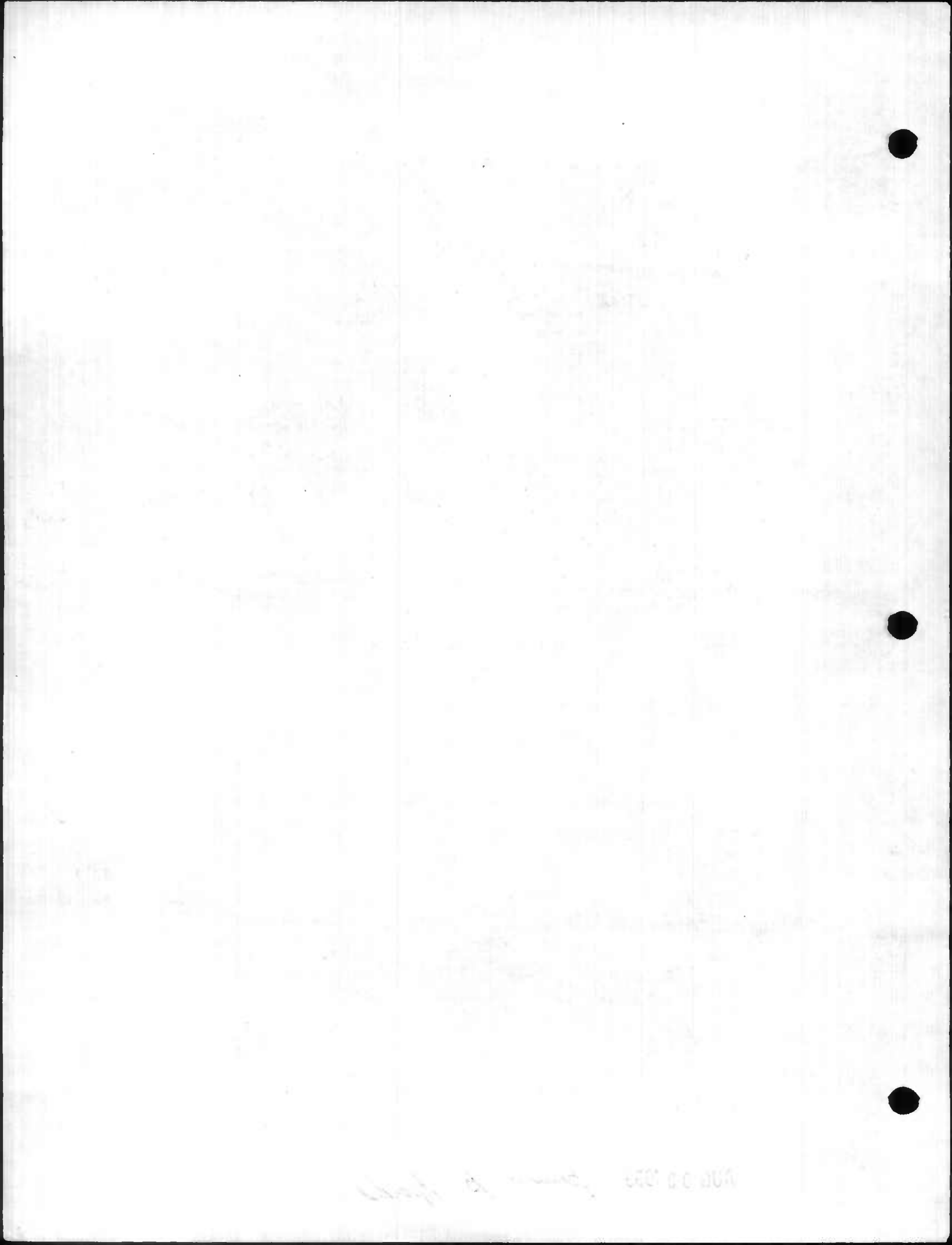
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24168**
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|-------------|---|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANNA ADAMS | | | | 2. Date of Death Month Day Year JULY 15, 1999 | | | | 3. Time of Death 3 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) GREENSPRING NSG. REHAB CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death CITY | | |
| Funeral Director | 5. Social Security Number 247-26-6210 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 13, 1913 | | 9. Birthplace (State or Foreign Country) SOUTH CAROLINA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 1105 E. CHASE ST. | | | | 10f. Zip Code 21202 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: AFRO. AMERICAN | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEAKER | | | | 16b. Kind of Business/Industry HOME | | | |
| 17. Father's Name (First, Middle, Last) ISIAH ADAMS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) CRESSE ADAMS | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) IDA ADAMS | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 STODDARD ST. BALTIMORE, MARYLAND 21201 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMTERY | | Date 7/23/99 | | 20c. Location - City or Town, State LANSDOWN, MD. | | | |
| 21. Signature of Funeral Service Licenses | | | | 22. Name and Address of Facility ESTEP BROTHERS FUNERALSER. P A. 1300 EUTAW PLACE, BALTIMORE, MD. | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER BLADDER-METASTATIC Due to (or as a consequence of): b. CANCER BLADDER Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. URINARY TRACT INFECTION | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier A. Adams, ATTENDING Physician | | | | 29c. License number D 13248 | | | | 29d. Date signed (Month, Day, Year) JULY 22, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADAM S. SIEGEL 1510 W. MOSHER STREET, BALTIMORE, MARYLAND 21217 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

CC.

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

CJ
Michael T.
Arbogast
AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 8-11-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

WR
Certificate of Death

Reg. No.

99 24169

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) MICHAEL TODD ARBOGAST | | 2. Date of Death Month July Day 31 Year 1999 | | 3. Time of Death 10:37 PM. | |
| 4a. Facility Name (If not institution, give street and number) North Arundel Hospital | | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death Anne Arundel |
| 5. Social Security Number 214-11-2705 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 28 Yrs. | If Under 1 Year Months 0 Days 0 | If Under 24 Hrs. Hours 0 Min. 0 | 8. Date of Birth (Month, Day, Year) NOV. 9, 1970 |
| 9. Birthplace (State or Foreign Country) MARYLAND | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MARYLAND | 10b. County ANNE ARUNDEL | 10c. City, Town or Location GLEN BURNIE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7713 OVERHILL ROAD | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER | | 16b. Kind of Business/Industry CONSTRUCTION | | | |
| 17. Father's Name (First, Middle, Last) CHARLES LEMUEL ARBOGAST, JR. | | | 18. Mother's Name (First, Middle, Maiden Surname) BARBARA JEAN HITE | | |
| 19a. Informant's Name/Relationship (Type, Print) (FATHER) MR. CHARLES LEMUEL ARBOGAST | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7713 OVERHILL ROAD, GLEN BURNIE, MARYLAND 21060 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CRESTLAWN MEMORIAL PARK | | 20c. Location - City or Town, State 8/4/99 MARRIOTTSTVILLE, MD. | |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | |

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

| | | | |
|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 7-31-99 28b. Time of Injury Found: 10:00 P M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred UNKNOWN 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7713 OVERHILL ROAD GLEN BURNIE, MARYLAND | |
| 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | |
| 29d. Date signed (Month, Day, Year) August 2, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Arbogast 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year) AUG 4 1999 | | 32. Registrar's Signature | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

99 24170

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence B. Allard

2. Date of Death

Month Day Year
July 31, 1999

3. Time of Death

3:40am

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-05-3289

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
May 29 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

Baltimore

10c. City, Town or Location

Glen Arm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11630 Glen Arm Rd.

10f. Zip Code

21057

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Balt. Co. Board of Ed.

17. Father's Name (First, Middle, Last)

Elmer Beever

18. Mother's Name (First, Middle, Maiden Surname)

Edna Franks

19a. Informant's Name/Relationship (Type, Print)

Col. C. Kenneth Allard/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1809 Stirrup Ln. Alexandria, Va. 22308

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Cemetery

Date

8-3-99

20c. Location - City or Town, State

Parkville, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EMBOLISM

Due to (or as a consequence of):

b. Congestive Cardiac Failure

Due to (or as a consequence of):

c. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

d. Hyperlipidemia

Approximate Interval Between Onset and Death

6 hours

3 years

15 years

45 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

Asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D51228

29d. Date signed (Month, Day, Year)

7/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROMANA GOPALAN MD
2 EAST ROLLING CROSSLANDS #59 BALTIMORE MD 21228

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

[Signature]

State
RegistrarTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

0110141 H0161054

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

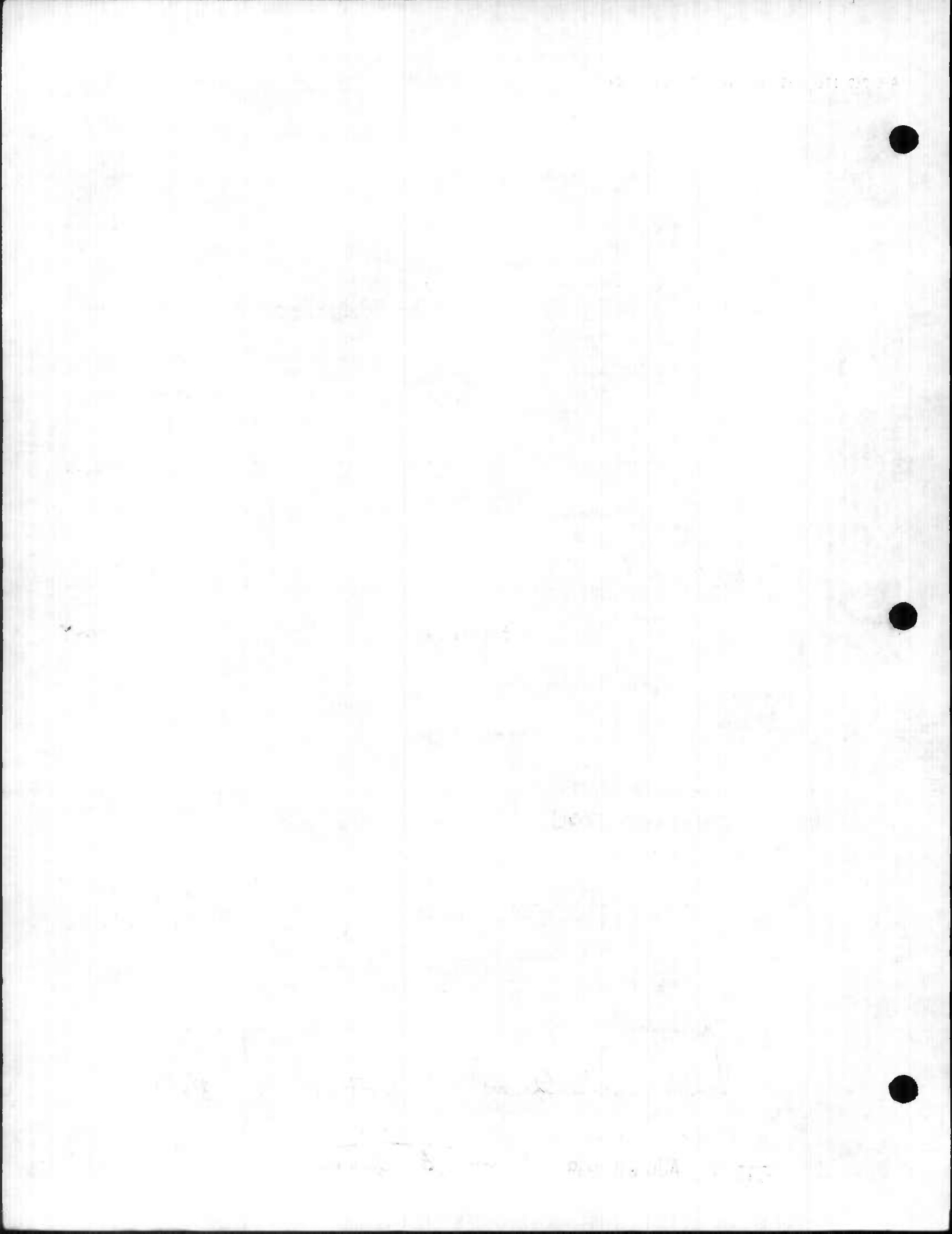
Certificate of Death

AMENDED ITEM #31 per dvr G774 8/3/99 AH

Reg. No. 99 21171

| | | | | | | | | | | |
|--|---|---|---|--------------------------------------|---|---|--|---|------------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret L. Bunce | | | | 2. Date of Death Month Day Year July 31, 1999 | | | | 3. Time of Death 11:00AM | |
| | 4a. Facility Name (If not institution, give street and number) Harborside Health Care | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-14-9300 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 26, 1910 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County N/A | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 1657 East Belvedere Avenue | | | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) Henry Leonard | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Rammes | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Leonard Bunce/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4122 Townsend Avenue, Baltimore, Maryland 21225 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park | | Data 08/03/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Christina L. David Christina L. David | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MALNUTRITION Due to (or as a consequence of): | | | | | | | | | Approximate Interval Between Onset and Death 1 DAY |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MALNUTRITION | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier James P. Richardson MD | | 29c. License number 027394 | | 29d. Date signed (Month, Day, Year) 8/2/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doctor James Paul Richardson, M.D., M.P.H. 5001 Loch Raven Blvd. P.O. Suite 209, Baltimore, Md. 21239 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) 8/2/99 | | 32. Registrar's Signature B. Sparks | | | | | | | | |

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24172

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ariel Brown

2. Date of Death

Month
7Day
23Year
99

3. Time of Death

03:42

4a. Facility Name (If not institution, give street and number)

University of Maryland

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

n/a

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

6 20

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

1-3-99

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6219 Shipview Way

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Infant

16b. Kind of Business/Industry

Infant

17. Father's Name (First, Middle, Last)

James L. Brown Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia A. Brown

19a. Informant's Name/Relationship (Type, Print)

Sylvia A. Brown (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6219 Shipview Way, Baltimore, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Cemetery

Data

7/31/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Ann Zink

22. Name and Address of Facility

Loudon Park Funeral Home
3620 Wilkens Ave. Baltimore, Md 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Epidermolysis Bullosa

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alice D Ackerman

29c. License number

D31670

29d. Date signed (Month, Day, Year)

7/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice D Ackerman

University of Maryland Hosp

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

Brenda B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Resigning

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24173**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) RICHARD A. BUSCH | | | | | | 2. Date of Death Month AUG Day 2 Year 1999 | | 3. Time of Death 11:22 am | |
| 4a. Facility Name (If not institution, give street and number) 1410 East-West Shady Side Road | | | | | | 4b. City, Town, or Location of Death Shady Side | | 4c. County of Death Anne Arundel | |
| 5. Social Security Number 040-03-9754 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 29, 1915 | | 9. Birthplace (State or Foreign Country) California | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Shady Side | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1410 East-West Shady Side Road | | | | | | 10f. Zip Code 20764 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector | | | 16b. Kind of Business/Industry OSHA | | |
| 17. Father's Name (First, Middle, Last) August Busch | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rose Albrecht | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jane Y. Busch (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1410 East-West ShadySide Rd., Shady Side, MD 20764 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 08/06 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Stroke</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 4 days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number 005158 | |
| | | | | 29d. Date signed (Month, Day, Year) Aug 2 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARVEY J STEINFELD SHADYSIDE RD 20764 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24174

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Butler

2. Date of Death

7 22 99 8:22am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Millennium of Liberty Heights Bldg. MD

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

217-09-1238

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10 8 10

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

702 DOLPHIN STREET APT 1 F

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

labor

16b. Kind of Business/Industry

COCA COLA

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

ABERTA BUTLER

19a. Informant's Name/Relationship (Type, Print)

GLORIA CRAWFORD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2526 RIGGS AVE. BALTIMORE MARYLAND 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT ZION CEMETERY

Date

7-29-99 BALTIMORE MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Lloyd M Estep

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTIMORE MARYLAND 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on this line.Immediate Cause (Final
disease or condition
resulting in death)

a. prostate cancer

Due to (or as a consequence of):

b. penile cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

10 yrs

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of injury
(Month, Day, Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mia - O King, MD

29c. License number

031865

29d. Date signed (Month, Day, Year)

7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rm 206 821 N Antares Street, Baltimore Md 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. B. Spaul

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

March 15 1900
Office
Department of the Interior
Washington, D.C.
No. 10

Black

John M. Smith

and a small amount

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 24175

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SIRETA T BURRELL

2. Date of Death
Month Day Year

7 18 1999 3:15 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

BON SECOURS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

214-64-6316

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

36 Yrs.

8. Date of Birth (Month, Day, Year)

8-7-62

9. Birthplace (State or Foreign Country)

md.

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

500 GLEN ALLEN DRIVE

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

WALTER BURELL

18. Mother's Name (First, Middle, Maiden Surname)

DEBRA BURELL

19a. Informant's Name/Relationship (Type, Print)

DEBRA BURELL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

500 GLEN ALLEN DR. BALTIMORE MARYLAND 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

mt zion cenetery

Date

7-24-99 BALTIMORE MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTIMORE MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bilateral Pneumonia

Due to (or as a consequence of):

b. Encephalopathy

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetic Keto Acidosis

Acute Myocardial Infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anil Uberoi MD

29c. License number

D26748

29d. Date signed (Month, Day, Year)

7/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANIL UBEROI MD 4419 FALLS RD BALTO MD 21211

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

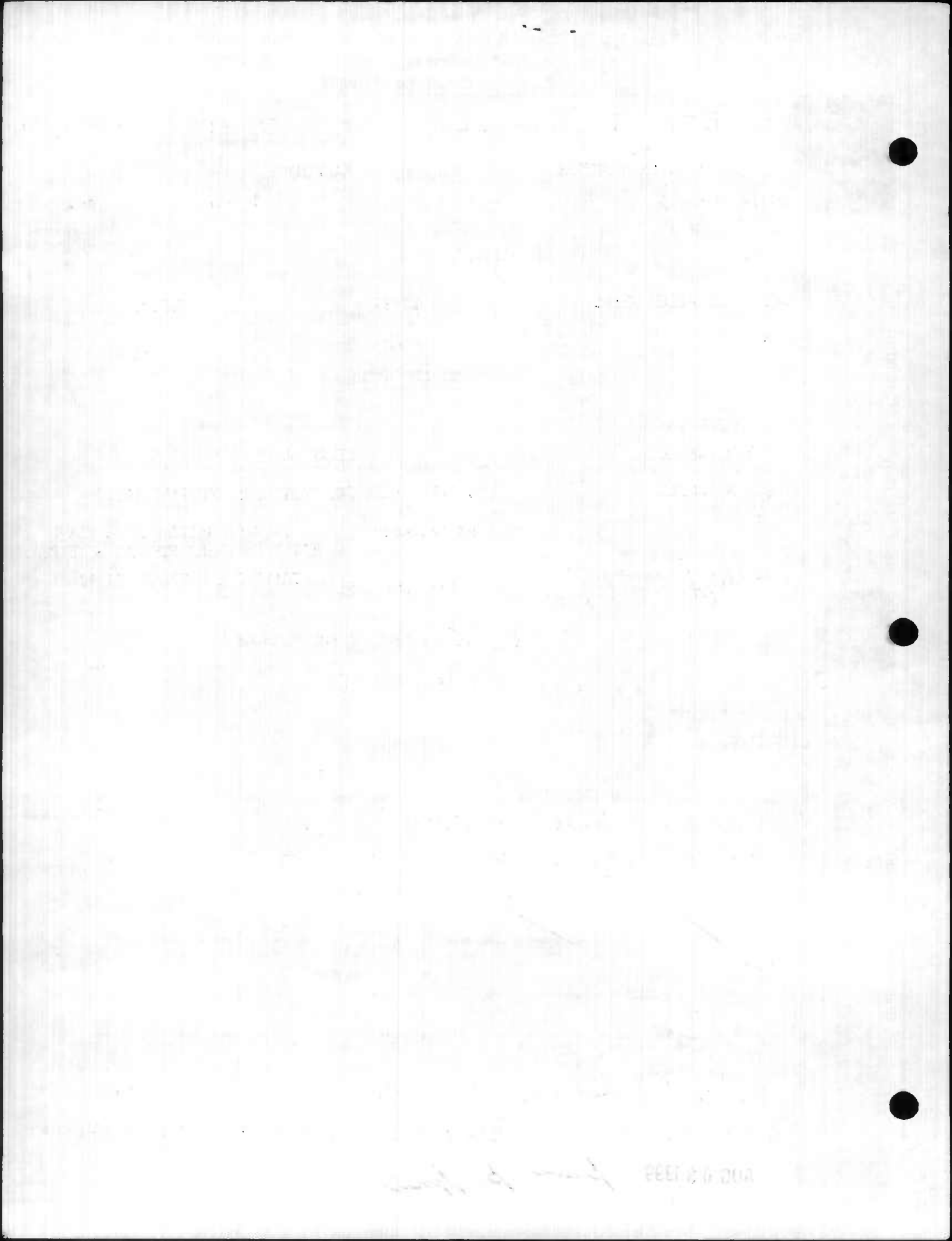
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

7/14



[Faint signature or stamp]

PETER G. DOR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24176

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | |
|--|--|---|--|--|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) James Theodore Beverly, Sr. | | | | 2. Date of Death Month <u>July</u> Day <u>24</u> Year <u>1999</u> | | | | 3. Time of Death <u>4:30 AM</u> | |
| 4e. Facility Name (If not institution, give street and number) Northwest Hospital | | | | 4b. City, Town, or Location of Death Randallstown | | | | 4c. County of Death Baltimore | |
| 5. Social Security Number 219-05-0012 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 | | 8. Date of Birth (Month, Day, Year) May 19, 1914 | | 9. Birthplace (State or Foreign Country) Md. | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2302 W. Mosher Street | | | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist | | | 16b. Kind of Business/Industry Western Electric | | |
| 17. Father's Name (First, Middle, Last) George Sterling | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Beverly | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James T. Beverly, Jr. son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 W. Mosher Street Baltimore, Md. 21216 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery | | Date July 31 | | 20c. Location - City or Town, State Baltimore, Md. | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arteriosclerotic Cardio Renal Vascular Disease Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| b. Due to (or as a consequence of): | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Dehydration & Deambulation | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D-09383 | | 29d. Date signed (Month, Day, Year) July 25, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles F. O'Donnell MD Baltimore Md 21210 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24177
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET MARIE BERGER

2. Date of Death

Month JULY Day 28 Year 1999 11:15 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

130-12-1157

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Mar. Day 17, Year 1921

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

205 Deep Dale Dr.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Department Manager

16b. Kind of Business/Industry

Sears Co.

17. Father's Name (First, Middle, Last)

Augus

Maylahn

18. Mother's Name (First, Middle, Maiden Surname)

Ida

Salzwedel

19a. Informant's Name/Relationship (Type, Print)

Mrs. Theresa Lioi/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 Deep Dale Dr. Lutherville, Md. 21093

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Druid Ridge Cemetery

Date

7/30/99

20c. Location - City or Town, State

Pikesville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

MULTIPLE ORGAN FAILURE DUE TO SEPSIS

Approximate
Interval Between
Onset and Death

12 DAYS

Immediate Cause (Final
disease or condition
resulting in death)Due to (or as a consequence of):
SECONDARY TO PERFORATED GASTRIC ULCERSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastDue to (or as a consequence of):
W/GENERALIZED PERITONITIS AND PNEUMONIA

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical ExaminerOn the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 26954

29d. Date signed (Month, Day, Year)

07-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEMY CHHIM M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24178

Patient known as Pauline Cardwell
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | |
|---|--|---|--------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) <u>Pauline Cardwell</u> | | 2. Date of Death Month <u>August</u> Day <u>1</u> Year <u>1999</u> | | 3. Time of Death <u>05:45</u> |
| 4a. Facility Name (If not institution, give street and number) <u>Sinai Hospital of Baltimore</u> | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>NA</u> |
| 5. Social Security Number <u>410-42-1209</u> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>86</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| 8. Date of Birth (Month, Day, Year) <u>Oct. 12, 1912</u> | | 9. Birthplace (State or Foreign Country) <u>TN</u> | | |
| Usual Residence of Decedent | | | | |
| 10a. State <u>MD</u> | 10b. County <u>NA</u> | 10c. City, Town or Location <u>Baltimore</u> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number <u>4800 Yellowwood Ave</u> | | 10f. Zip Code <u>21209</u> | | 10g. Citizen of What Country? <u>USA</u> |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u>2 yrs</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>L. P. N.</u> | | 16b. Kind of Business/Industry <u>Private Duty</u> |
| 17. Father's Name (First, Middle, Last) <u>Charles Shields</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Annie Carmichael</u> | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Peggy Deayton-Daughter</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1801 W. Rogers Ave. Balto. Md. 21209</u> | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u> | | 20c. Date <u>8.5.99</u> |
| 20d. Location - City or Town, State <u>Balto. Md</u> | | | | |
| 21. Signature of Funeral Service Licensee <u>Myron B. Harris</u> | | 22. Name and Address of Facility <u>Mark Funeral Home West Inc. 4300 Wabash Ave. Balto. Md. 21215</u> | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. <u>Myocardial Infarction</u> Due to (or as a consequence of): | | Approximate Interval Between Onset and Death <u>Days</u> |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. <u>Coronary Artery Disease</u> Due to (or as a consequence of): | | <u>Years</u> |
| c. | | Due to (or as a consequence of): | | |
| d. | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier <u>[Signature]</u> | | 29c. License number <u>D0053607</u> | | 29d. Date signed (Month, Day, Year) <u>August 1, 1999</u> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Paul G. Burns 7505 Oder Drive, Suite 306 Tanson, MD</u> | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 03 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24179

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lee F. Chapman | | | | 2. Date of Death Month Day Year JULY 30, 1999 | | | | 3. Time of Death 12:47 AM | |
| | 4a. Facility Name (If not institution, give street and number) JOHN HOPKINS BAYVIEW MEDICAL CENTER E.R. | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-19-1956 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 20 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 11 1978 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location St. Helena | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 6510 Cleveland Ave | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Alarm Technician | | | 16b. Kind of Business/Industry Electronics | | |
| | 17. Father's Name (First, Middle, Last) Daniel E. Chapman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sandra B. Gerhart | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Sandra Hackman /mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Township Rd Baltimore, MD 21222 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | Data Aug 4 1999 | | 20c. Location - City or Town, State Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee Anthony C. Connelly | | | | 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Injuries | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7/30/99 | | 28b. Time of Injury 0010 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred motorcycle operator collides with vehicle | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street; 7601 Eastern Ave; Baltimore, Md. | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier J. Pestaner, MD | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) JULY 30, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |
| | State Registrar | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24180

| | | | | | | | | | | | |
|---|--|-----------------------|---|---|--|--------------------------------------|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joan M. Chojnacki | | | | 2. Date of Death Month Day Year July 30 1999 | | | | 3. Time of Death 10:24 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Mercy Stella Maris Hospice | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 216-34-0710 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) May 28 1937 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Colombia | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 5459 Blue Coat Lane | | | | 10f. Zip Code 21045 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Data entry clerk | | | | 16b. Kind of Business/Industry Accounting | | | |
| 17. Father's Name (First, Middle, Last) John Kolacz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Caroline Perk | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Karen Orlando /daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7534 School Ave Baltimore, MD 21222 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date Aug 3 1999 | | 20c. Location - City or Town, State Catonsville, MD | | | |
| 21. Signature of Funeral Service Licensee Anthony C. Connelly | | | | 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung CA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier David Scharff, M.D. | | | | 29c. License number D42908 | | | | 29d. Date signed (Month, Day, Year) August 2, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Scharff, M.D. 808 S. Conkling St Baltimore, MD | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature Dana B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24181

| | | | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sadie Conley | | | | 2. Date of Death Month 7 Day 29 Year 99 | | | | 3. Time of Death 755 AM | | | | |
| | 4a. Facility Name (If not institution, give street and number) Millennium Health+Rehab 4017 Liberty Hgts Ave | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death n/a | | | | |
| Funeral Director | 5. Social Security Number 218-22-2434 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) 3-14-14 | | 9. Birthplace (State or Foreign Country) Md. | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 1643 McKean Avenue | | | | 10f. Zip Code 21217 | | | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | | | 16b. Kind of Business/Industry Private Families | | | | | |
| 17. Father's Name (First, Middle, Last) Theodore Blackwell | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie unknown | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Husband George H. Conley | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1643 McKean Avenue Baltimore, Md. 21217 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forrest Veterans | | | | Date Aug. 4 | | 20c. Location - City or Town, State Owings Mills, Md. | | | |
| 21. Signature of Funeral Service Licensee H. Herbert E. Nutter | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Lung & Liver Cancer metastasis 6 wks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Amatun H. Naeem MD | | | | 29c. License number D 15503 | | 29d. Date signed (Month, Day, Year) 7/30/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMATUN H. NAEEM, 501 Dolphin St Balto MD 21217 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature G. Sparks | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24182

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Miller Caner

2. Date of Death

July 29, 1999

3. Time of Death

2:55 PM

4a. Facility Name (If not institution, give street and number)

Edenwald - Strou Hall

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-32-0978

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6-7-1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

800 Southerly Road

10f. Zip Code

21286

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Baltimore City Schools

17. Father's Name (First, Middle, Last)

Edward C. Miller

18. Mother's Name (First, Middle, Maiden Surname)

Mary Miller Baynard

19a. Informant's Name/Relationship (Type, Print)

Julia C. Benefield (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

124 Margate Road, Lutherville, Maryland 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

7-31-99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Road, Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Stroke

Approximate Interval Between Onset and Death

6 hours

Due to (or as a consequence of):

b. Chronic Atrial Fibrillation

10 years

Due to (or as a consequence of):

c. Atherosclerotic Cardiovascular Disease

30 years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

[Signature]

29c. License number

D34124

29d. Date signed (Month, Day, Year)

7-30-99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

John D. Miltz, MD 1205 York Rd #20 LUTHERVILLE, MD 21093

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Signature of Registrar

[Signature]

State
Registrar

Margaret M. Caner
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24183

| | | | | | | | | | |
|---|---|--|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Henry Dunton, Sr. | | | | 2. Date of Death Month Day Year July 28, 99 | | 3. Time of Death 12:55pm | | |
| | 4a. Facility Name (If not institution, give street and number) 1010 W. Baltimore Street Apt. #105 | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | | |
| Funeral Director | 5. Social Security Number 216-34-0606 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 62 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 02-14-37 | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 1010 W. Baltimore Street | | | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor | | 16b. Kind of Business/Industry Regel Laundry | | | |
| 17. Father's Name (First, Middle, Last) William H. Dunton | | | | 18. Mother's Name (First, Middle, Maiden Surname) Irene Murray | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mamie Dunton | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4422 Marble Hall Road Apt. #362 Baltimore, MD 21218 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Western Star Cemetery | | 20c. Location - City or Town, State 08-03-99 Catonsville, MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | | |
| 23a. Pad 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION TYPE 2 DIABETES MELLITUS | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D30272 | | 29d. Date signed (Month, Day, Year) AUGUST 2, 1999 | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) THOMAS S. MILLER 700 WASHINGTON BLVD BALTO MD 21230 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

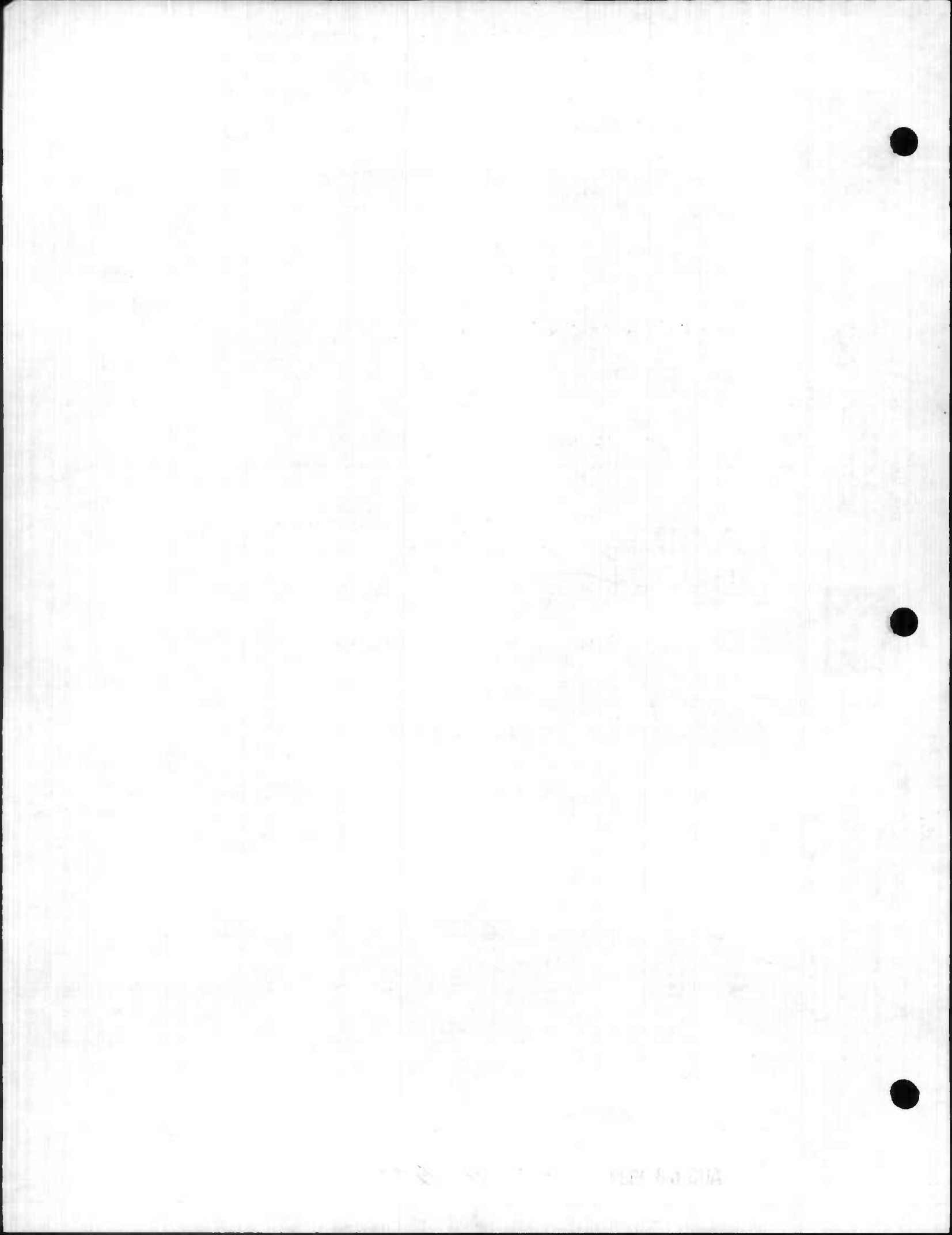
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24184

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Virgil Lee Daughtry | | | | 2. Date of Death Month Day Year JULY 31, 1999 | | 3. Time of Death 12:23 PM | |
| | 4a. Facility Name (If not institution, give street and number) 4310 CARLEVIEW ROAD | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 228-50-3887 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 10-2-1930 | | 9. Birthplace (State or Foreign Country) N.C. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md | 10b. County N/A | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 4310 Carleview Road | | | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? U S A | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade | | College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Blue print | | 16b. Kind of Business/Industry Md Shipbuilding & Drydock | |
| | 17. Father's Name (First, Middle, Last) Robert Daughtry | | | | 18. Mother's Name (First, Middle, Maiden Sumame) Rosa Purvis | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Naomi Moore- Sister | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4310 Carleview Road Baltimore, Md 21207 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet | | Date 8-5-99 | | 20c. Location - City or Town, State Owings Mills, Md | |
| | 21. Signature of Funeral Service Licensee Gabrielle Clark | | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Approximate Interval Between Onset and Death | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier [Signature] | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUG. 2, 1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON WICKS MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24185

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel Di Pietro

2. Date of Death
Month Day YearAugust 1st 19993. Time of Death
01:30A

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Geriatrics Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

217-32-7554

6. Sex

1st M 2nd F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

4-19-1919

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1st Yes 2nd No

10e. Street and Number

4940 Eastern Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1st Never Married 2nd Married
3rd Widowed 4th Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1st Yes 2nd No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1st Yes 2nd No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

2nd

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Gaetano DiPietro

18. Mother's Name (First, Middle, Maiden Surname)

Anna D'Andrea

19a. Informant's Name/Relationship (Type, Print)

Mrs. Lena Jansen

sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7044 Eastern Ave., Baltimore, Maryland 21224

20a. Method of Disposition

1st Burial 2nd Cremation 3rd Removal from State
4th Donation 5th Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Jesus

Date

8/3/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Maria J. Zannino

22. Name and Address of Facility

Joseph N. Zannino Jr, Funeral Hm.
263 S. Conkling Street, Baltimore, Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastro Intestinal Bleeding

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. S/D Sigmoid Volvulus with colectomy and ileostomy 5 yrs

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UTI

23b. Did tobacco use contribute to the cause of death?

1st Yes 2nd No 3rd Probably 4th Unknown

24a. Was an autopsy performed?

1st Yes 2nd No

24b. Were autopsy findings available prior to completion of cause of death?

1st Yes 2nd No

25. Was case referred to medical examiner?

1st Yes 2nd No

Hospital:

1st Inpatient 2nd ER/Outpatient 3rd DOA

26. Place of Death (Check only one)

Other:

4th Nursing Home 5th Residence 6th Other (Specify)

27. Manner of Death

1st Natural 2nd Accident 3rd Suicide 4th Homicide
5th Pending investigation 6th Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1st Yes 2nd No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2nd Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. Kaffenbarger

29c. License number

D 51636

29d. Date signed (Month, Day, Year)

August 1st 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Kaffenbarger 4940 Eastern Ave Geriatric Ctr. Baltimore MD

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-261-2000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24186

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|---|--|---|---|---|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Anna Dircks | | | | 2. Date of Death Month Day Year July 29 1999 | | | | 3. Time of Death 4:10 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Mariner Health of Forest Hill | | | | 4b. City, Town, or Location of Death Forest Hill | | | | 4c. County of Death Harford | | |
| Funeral Director | 5. Social Security Number 219-50-3155 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 | | 8. Date of Birth (Month, Day, Year) Sept. 5, 1907 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore County | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 410 Carrollwood Rd. | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5th grade N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | | | 16b. Kind of Business/Industry Housekeeping - Own Home | | | |
| 17. Father's Name (First, Middle, Last) Christian Dietz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Katherine Hanf | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Walter H. Dircks | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9704 Gaylord St. White Marsh, Maryland 21162 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Michaels Ch. Cem. | | 20c. Location - City or Town, State Baltimore, Md. | | | | | |
| 21. Signature of Funeral Service Licensee E. F. Lassahn | | | | 22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. old age | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier William M. H. 40 | | | | 29c. License number D 32609 | | | | 29d. Date signed (Month, Day, Year) 7/30/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kammelen Metham MD 703 Revolution St. Havre De Grace MD 21078 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24187

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|--|--|--|---|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Penelope Daoutis | | | | 2. Date of Death Month: July Day: 31 Year: 1999 | | | | 3. Time of Death 4:06pm | | | |
| | 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 218-68-7236 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) March 12, 1913 | | 9. Birthplace (State or Foreign Country) Greece | | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 2804 St. Paul Street | | | | 10f. Zip Code 21218 | | | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): | | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | | 17. Father's Name (First, Middle, Last) Petros Papanastasiou | | | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Sophia Unknown | | | | 19a. Informant's Name/Relationship (Type, Print) Kiveli Ranu / Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 St. Paul Street Baltimore, MD 21218 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greek Orthodox Cemetery | | | | 20c. Date 8/4/99 | | | |
| | 20d. Location - City or Town, State Woodlawn, Maryland | | | | 21. Signature of Funeral Service Licensee Timothy Harman | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Ischemic Bowel Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 1 day 5 day | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 23c. Were en autopsies performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| Physician /Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Joanne Watson MD | | | | 29c. License number AU4176435 | | | |
| | 29d. Date signed (Month, Day, Year) July 31, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joanne Watson MD UMH 201st University PKWY Balt MD 21218 | | | | 31. Date filed (Month, Day, Year) AUG 03 1999 | | | |
| | 32. Registrar's Signature B. Sparks | | | | State Registrar | | | | DHHM 16 Rev 6/95 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

99-166 unk
99-4457-510
asp

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24188

CHARLES ELBECK

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

CHARLES ELBECK

2. Date of Death

Month
JULY

Day
28

Year
1999

3. Time of Death

2252

4a. Facility Name (If not institution, give street and number)

700 BLK N. MONROE ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

219-74-8243

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
8-10-1958

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5100 GOODNOW ROAD

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

STERLING ELBECK

18. Mother's Name (First, Middle, Maiden Surname)

ALICE ELBECK

19a. Informant's Name/Relationship (Type, Print)

BARBARA ELBECK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5100 GOODNOW RD. BALTIMORE MARYLAND 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT ZION CEMETERY

Date

8-3-99

20c. Location - City or Town, State

BALTIMORE MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A.

1300 EUTAW PLACE BALTIMORE MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cervical Wounds of Head and Neck

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

7/28/99

28b. Time of Injury

2242 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Shoot Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

700 Blk. N. Monroe St.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Spahr

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text, possibly a signature or date, located in the middle of the page.

Handwritten text at the bottom of the page, possibly a date or reference number.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24189

AMEND ITEMS: #23 PART I, 27 PER MEO G774 8-25-99 WR. Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Keith Gregory Evans | | | | 2. Date of Death Month Day Year JULY 27, 1999 | | 3. Time of Death 2055 PM | |
| | 4a. Facility Name (If not institution, give street and number) 3301 DORITHAN ROAD APARTMENT 246 | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number UNK | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 7-21-1953 | 9. Birthplace (State or Foreign Country) Md | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md | 10b. County N/A | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 3301 Dorithan Road | | | 10f. Zip Code 21244 | | 10g. Citizen of What Country? U S A | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade | | College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing Assistance | | 16b. Kind of Business/Industry Hospital | |
| | 17. Father's Name (First, Middle, Last) Major Evans | | | | 18. Mother's Name (First, Middle, Maiden Summa) Julia Wilson | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Julia & Major Evans- Parents | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3429 Merle Drive Baltimore, Md 21244 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State 7-30-99 Randallstown, Md | | | |
| | 21. Signature of Funeral Service Licensee Bladys Wanes | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier Hospitals Michael J. Smith | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 28, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospitals A. KOSU 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature James B. Sparks | | | | | |

VOID

CERTIFICATE #

99-24190

SEE

CERTIFICATE #

~~11111~~

NUMBERED OVER A
#98-PRE-EXISTING NUMBER

98-36960

AIR READY FILED

WRC
99-4517-005
FREDERICK F.
EBERT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24191

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Frederick F. Ebert Jr. | | | | 2. Date of Death Month AUG. Day 01, Year 1999 | | 3. Time of Death 6:25 PM. | |
| 4a. Facility Name (If not institution, give street and number) 3103 DUNDALK AVE. | | | | 4b. City, Town, or Location of Death DUNDALK | | 4c. County of Death Baltimore | |
| 5. Social Security Number 213-62-3260 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 41 Yrs. | | 8. Date of Birth (Month, Day, Year) May 31 1958 | |
| 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 3103 Dundalk Ave | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Store Manager | | 16b. Kind of Business/Industry Auto Glass | | | |
| 17. Father's Name (First, Middle, Last) Frederick F. Ebert Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Frances Mrozinski | | | |
| 19a. Informant's Name/Relationship (Type, Print) Denise Ebert /wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3103 Dundalk Ave Baltimore, MD 21222 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cem | | Date Aug 7 1999 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee Anthony C. Connolly | | | | 22. Name and Address of Facility Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intra-oral gunshot wound Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? Limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 8-1-99 | | 28b. Time of Injury 1800 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred subject shot self | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3103 Dundalk Ave Baltimore County, Maryland | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Stephen A. Radentz, MD | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUG. 02, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24192

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret A. Evering

2. Date of Death

July 29, 1999

3. Time of Death

8:00 am

4a. Facility Name (If not institution, give street and number)

1021 Chesaco Ave.

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-10-7976

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-23-10

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1021 Chesaco Ave.

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles J. Horner Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Fischer

19a. Informant's Name/Relationship (Type, Print)

Frances Restivo / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1021 Chesaco Ave. Rosedale, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer

Date

8-2-99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cvach/Rosedale Funeral Home

1211 Chesaco Ave. Rosedale, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST
Due to (or as a consequence of):

acute

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. H.A.S.C.V.D.
Due to (or as a consequence of):

30 yrs

c. INSULIN DEPENDENT DIABETES
Due to (or as a consequence of):

43 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- METASTATIC MALIGNANT MELANOMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

D07132

29d. Date signed (Month, Day, Year)

7/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24193

| | | | | | | | | |
|--|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Andrew Filkohazi | | | | 2. Date of Death Month June Day 5 Year 1999 | | 3. Time of Death 12:30 pm | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Woods Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 154-03-5139 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 48 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 19, 1950 | 9. Birthplace (State or Foreign Country) unknown |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 3 Maple Drive | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status unknown <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? unknown <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: unknown | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4or 5+) unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | 16b. Kind of Business/Industry unknown | | |
| 17. Father's Name (First, Middle, Last) unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) unknown | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) unknown | | 20c. Location - City or Town, State unknown | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| a. LUNG CANCER Due to (or as a consequence of): | | | | | | | | 12 MTHS |
| b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): | | | | | | | | 8 YEARS |
| c. _____ Due to (or as a consequence of): | | | | | | | | |
| d. _____ Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier D.O. | | | | | | |
| | | 29c. License number H35593 | | 29d. Date signed (Month, Day, Year) JULY 29, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JOHN J. LOH 1129 MACE AVE., BALTIMORE. MD. 21221 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Apata | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #1 PER MD G774 8/3/99 AH

Certificate of Death

Reg. No.

99 24194

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GRACE GRACE ELIZABETH SMITH ASMUS FONES | | | | 2. Date of Death Month Day Year JULY 30 1999 | | 3. Time of Death 12:55 | |
| | 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 079-10-8805 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Apr 8 1918 | 9. Birthplace (State or Foreign Country) New York | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 353 D Homeland Southway | | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietician | | 16b. Kind of Business/Industry Hospital | | |
| 17. Father's Name (First, Middle, Last) Charles Baird Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Broadhead Clyne | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. Mark Stuart Asmus (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6433 Blenheim Road, Baltimore, Maryland 21212 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | Date 7/31/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee Martin D. Lawson | | | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION CEREBRO VASCULAR ACCIDENT | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier R. Altaha, M.D. | | 29c. License number P 12555 | | 29d. Date signed (Month, Day, Year) 07, 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BOULEVARD, BALTIMORE, MD 21239-2995 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 02 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

2013-2014

2013-2014

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24195

| | | | | | |
|---|--|---------------------------------|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARIA D GIERSCH | | 2. Date of Death Month JULY Day 29 Year 1999 | | 3. Time of Death 2:45 AM |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW HOSPITAL | | 4b. City, Town, or Location of Death BALTO. CITY | | 4c. County of Death MD |
| Funeral Director | 5. Social Security Number 212-20-0382 | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 75 Yrs. | 8. Date of Birth (Month, Day, Year) APRIL 6, 1924 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location MIDDLE RIVER | | 10d. Inside City Limits 1 Yes 2 No |
| | 10e. Street and Number 1403 Wilson Pt. Rd. | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? U.S.A |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) via | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | 16b. Kind of Business/Industry U.S.F + G COAP. | | |
| | 17. Father's Name (First, Middle, Last) ONUFRY DASCHUK | | 18. Mother's Name (First, Middle, Maiden Surname) BARBARA STOTSKY | | |
| | 19a. Informant's Name/Relationship (Type, Print) BARBARA HART | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7907 Roseland Ave, BALTO. MD 21237 | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hills Cemetery | | 20c. Location - City or Town, State MIDDLE RIVER, MD |
| Physician /Medical Examiner | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility HARTLEY MILLER Funeral Home CHTD. 7527 Harford Rd, BALTO. MD 21234 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | Immediate Cause (Final disease or condition resulting in death) e. Bradycardic arrest | | | | |
| | Due to (or as a consequence of): b. Lymphoma | | | | |
| To Be Completed by Physician/Medical Examiner | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| | Due to (or as a consequence of): c. d. Approximate Interval Between Onset and Death 10 minutes 2 YEARS | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 Yes 2 No | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | |
| | 25. Was case referred to medical examiner? 1 Yes 2 No | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) M | | 28b. Time of Injury M |
| | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| State Registrar | 29b. Signature and title of certifier | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) July 29, 1999 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUIS A. DIAZ, MD JOHNS HOPKINS HOSPITAL, BALTIMORE, MD | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24196
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jacqueline M. Gurski

2. Date of Death

AUGUST 2, 1999

3. Time of Death

2:00 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

176-16-3890

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6-19-21

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther Blvd. Apt. 1502

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Martin Marietta

17. Father's Name (First, Middle, Last)

Frank Miller Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Brennan

19a. Informant's Name/Relationship (Type, Print)

Henry S. Gurski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 Walther Blvd. Apt. 1502, Baltimore, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

8-5-99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cvach/Rosedale Funeral Home

1211 Chesaco Ave. Rosedale, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CEREBROVASCULAR THROMBOSIS

Approximate Interval Between Onset and Death
6 DAYS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41410

29d. Date signed (Month, Day, Year)

August 2nd, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER B. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

00-31-35 - Gurski, Jacqueline

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24197

Certificate of Death

Reg. No.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) URNER LYNN GOLDEN | | | | 2. Date of Death Month Day Year July 25, 1999 | | 3. Time of Death 18:15 |
| | 4a. Facility Name (If not institution, give street and number) Univ. of Maryland Medical System | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 217-42-9217 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 52 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) January 1, 1947 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Washington | 10c. City, Town or Location Hancock | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 6125 Sensel Road | | | 10f. Zip Code 21750 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Surveyor | | 16b. Kind of Business/Industry Service | | |
| | 17. Father's Name (First, Middle, Last) Roy C. Golden | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Grace Stottlemeyer | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Angela C. Rhodes/Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6125 Sensel Road Hancock, MD 21750 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Warfordsburg Presbyterian | | 20c. Location - City or Town, State Warfordsburg, PA | | 20d. Date 7/29/99 |
| | 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): Adult Respiratory Distress Syndrome b. Acute Renal Failure Due to (or as a consequence of): Liver Failure / multiple trauma c. Due to (or as a consequence of): d. | | | | | | 24 hours 27 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) JUNE 28 99 | | 28b. Time of Injury 6:47 pm | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred DRIVER IN MVA | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROAD | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1600 Rt. 16 ADAMS PENNSYLVANIA | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | | 29c. License number D51674 | | | 29d. Date signed (Month, Day, Year) July 27, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon Henry, M.D. 22 South Greene Street, Baltimore, MD 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature [Signature] | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

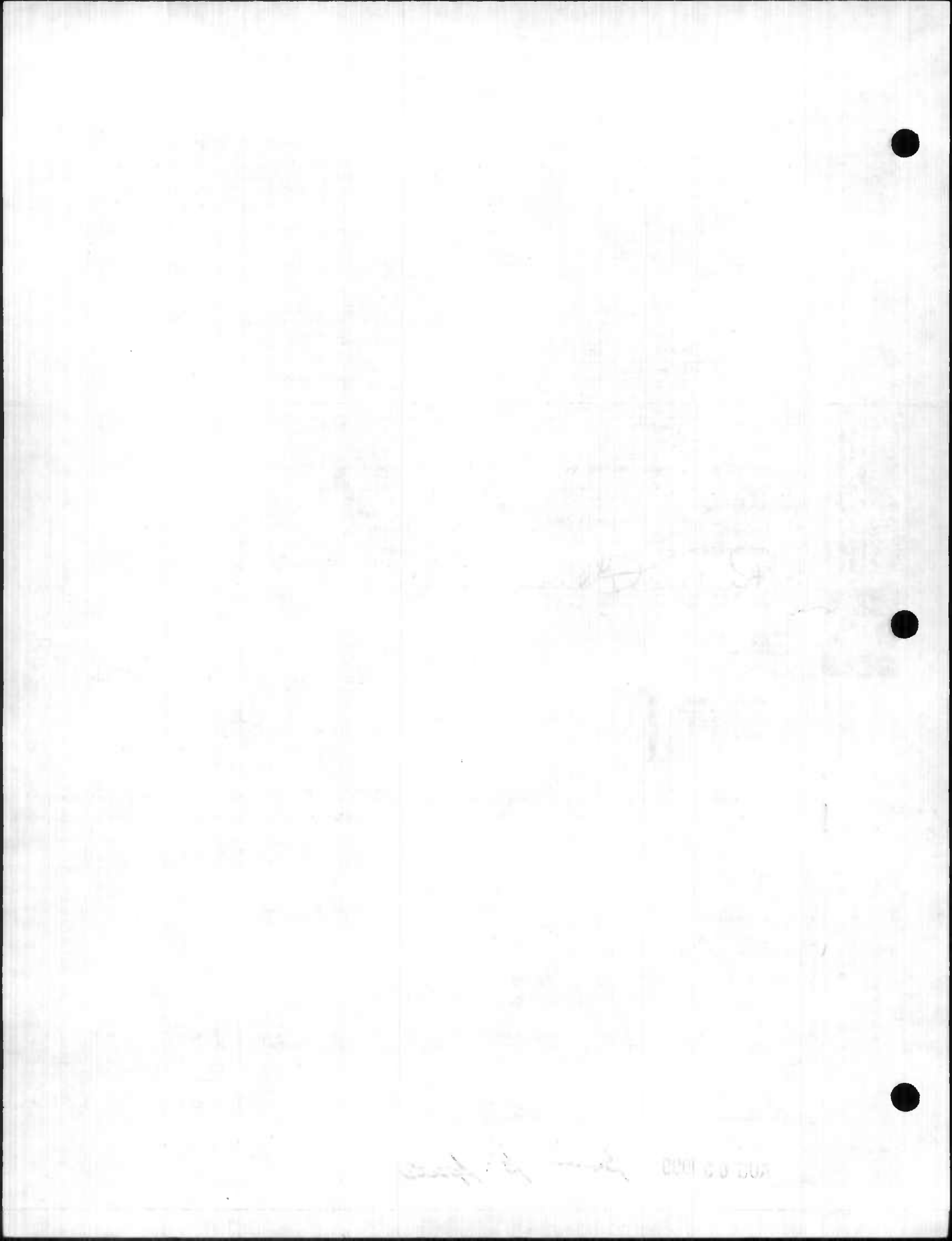
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Items#18,19aperFH,#26 perPhyG774 8/3/99 EW Certificate of Death

Reg. No.

99 24198

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | | |
|--|--|---------------------------------|---|---|--|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Mary Elizabeth Gray | | | | 2. Date of Death Month Day Year 07 26 1999 | | | | 3. Time of Death 1630 | | | |
| 4a. Facility Name (If not institution, give street and number) 13520 Route 108 | | | | | | 4b. City, Town, or Location of Death Highland | | | | 4c. County of Death Howard | |
| 5. Social Security Number 381-36-8646 | | | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) 12/02/1912 | | 9. Birthplace (State or Foreign Country) OH | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State TX | | 10b. County Fort Bend | | 10c. City, Town or Location Katy | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 20006 Chasestone Court | | | | 10f. Zip Code 77450 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Ssecondary (0-12) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | | 16b. Kind of Business/Industry Education | | | |
| 17. Father's Name (First, Middle, Last) Thomas G. Warren | | | | | | 18. Mother's Name (First, Middle, Maiden Summa) Nellie Wilson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joan Gotschman/Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13520 Route 108, Highland, Md 20777 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Balto-Wash Crematory | | | | 20c. Date 7/29 | | 20d. Location - City or Town, State Laurel, Md. | |
| 21. Signature of Funeral Service Licensee May K. Marshall | | | | | | 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>e. CARDIOMYOPATHY Due to (or as a consequence of):</p> <p>f. CORONARY ARTERY DISEASE Due to (or as a consequence of):</p> <p>g. MITRAL REGURGITATION Due to (or as a consequence of):</p> <p>h. AORTIC STENOSIS Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: right;"> <p>SEVEN YEARS</p> <p>SEVEN YEARS</p> <p>TWO YEARS</p> <p>FOUR YEARS</p> </div> </div> | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CAROTID ARTERY DISEASE | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Daughter's Residence | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Jonathan Safren MD ATTENDING PHYSICIAN | | | | | | 29c. License number MARYLAND D41711 | | 29d. Date signed (Month, Day, Year) JULY 28, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN SAFREN MD 3449 WILKENS AVENUE SUITE 300 BALTIMORE, MARYLAND 21229 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24199

| | | | | | | | | |
|--|--|---|--|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BERTHA GRIFFIN | | | | 2. Date of Death Month Day Year JULY 29 1999 | | 3. Time of Death 1850 Hrs. | |
| | 4a. Facility Name (If not institution, give street and number) NORTH WEST HOSPITAL | | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 217-24-9522 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 03-18-18 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1401 N. Lakewood Avenue | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (14 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry in home | | |
| 17. Father's Name (First, Middle, Last) Walter Patterson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Constance Washington | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marcelene P. Kibru | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4210 Dressage Court Randallstown, MD 21133 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | Date 08-04-99 | | 20c. Location - City or Town, State Anne Arundel, CO. MD. | | |
| 21. Signature of Funeral Service Licensee <i>S. Valencia Holland</i> | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE, DM II | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>C. Ravi MD</i> | | 29c. License number D37333 | | 29d. Date signed (Month, Day, Year) JULY 29, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. RAVI MD, NHC, BALTO. MD 21133 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature <i>B. Spauls</i> | | | | | | |

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-0000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

99 24200

Reg. No.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24201

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|---|--------------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EVELYN HUDGINS | | 2. Date of Death Month 7 Day 28 Year 99 | | 3. Time of Death 6:15 P.M. |
| | 4e. Facility Name (If not institution, give street and number) ANOR CARE ROLAND PARK | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death |
| Funeral Director | 5. Social Security Number 213 03 8435 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 12/21/08 | | 9. Birthplace (State or Foreign Country) | | |
| Usual Residence of Decedent | | | | | |
| 10e. State MD. | | 10b. County | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5430 PARK HEIGHTS AVE. | | 10f. Zip Code 21215 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) employee | | 16b. Kind of Business/Industry CITY OF BALTIMORE | | | |
| 17. Father's Name (First, Middle, Last) THOMAS B. HILL | | 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH HILL | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROSA BARNES | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 STODDARD CT. BALTIMORE MARYLAND 21201 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND NATIONAL CEMETERY 8-3-99 | | 20c. Location - City or Town, State laurel Md. | |
| 21. Signature of Funeral Service Licensee Calvin Bey | | 22. Name and Address of Facility ESTEP BROTHERS FUNERALHOME P A. 1300 EUTAW BL BALTIMORE, MD . 21217 | | | |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC CARCINOMA OF UNKNOWN PRIMARY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | Approximate Interval Between Onset and Death MONTAS TO YEARS | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTROINTESTINAL BLEEDING, CONGESTIVE HEART FAILURE | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier R. Rangarajan | | 29c. License number 000 54288 | | 29d. Date signed (Month, Day, Year) July 30th 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMASWAMY J. RANGARAJAN. 7445 A FURNACE BRANCH ROAD GLEN BURNIE, MD. 21060 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24202

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|--|---|---------------------------------|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIE HARRY | | | | 2. Date of Death Month Day Year JULY 26 1999 | | | | 3. Time of Death 2:00 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) STELLA MARIS AT MERCY HOSPICE | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 247-20-3743 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) june 12, 1919 | | 9. Birthplace (State or Foreign Country) SC. | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD. | | 10b. County | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 132 N. DENNISON STREET | | | | 10f. Zip Code 21229 | | | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EMPLOYEE | | | | 16b. Kind of Business/Industry BALTIMORE GAS AND ELECTRIC | | |
| 17. Father's Name (First, Middle, Last) NELSON HARRY | | | | 18. Mother's Name (First, Middle, Maiden Surname) FANNIE HARRY | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARY HARRY | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 N DENNISON STREET BALTIMORE MARYLAND 21229 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY | | Date 7-30-99 | | 20c. Location - City or Town, State BALTIMORE MARYLAND | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Severe Diabetic neuropathy Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how Injury occurred | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D44715 | | |
| | | | | 29d. Date signed (Month, Day, Year) 7-26-99 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FRANCIS X. STRAIN, M.D. | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24203

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EARLE HINCKLE

2. Date of Death

JULY 24 1999

3. Time of Death

7:45 AM

4a. Facility Name (If not Institution, give street and number)

JOSEPH RICHES HOSPICE 828 EUTAW STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

194-22-8058

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

FEBRUARY 25, 1929

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

305 E. 25th Street

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Doug Ross

29c. License number

D26327

29d. Date signed (Month, Day, Year)

July 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOUGLASS ROSS MD 6114 CAMPFIRE, COLUMBIA MD 21045

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,


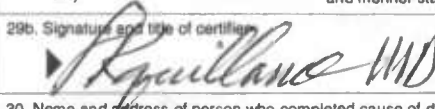

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24204

| | | | | | | | | |
|---|---|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOSEPH EARL HUBER, SR. | | | | 2. Date of Death Month JULY Day 28 Year 1999 | | 3. Time of Death 11:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216-18-0866 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 24, 1923 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Md. | | 10b. County Anne Arundel | | 10c. City, Town or Location Glen Burnie | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 110 Second Avenue South | | | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lineman | | 16b. Kind of Business/Industry B G E | | |
| 17. Father's Name (First, Middle, Last) George Huber | | | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes Lamarr | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Loretta B. Huber (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Second Avenue South Glen Burnie, Md. 21061 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | Date 8/2/99 | | 20c. Location - City or Town, State Elkridge, Maryland | | |
| 21. Signature of Funeral Service Licensee  Kevin E. Ecker | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. METASTATIC COLON CARCINOMA 2 YRS Due to (or as a consequence of): b. PROSTATE CARCINOMA 2 YRS Due to (or as a consequence of): c. CORONARY ARTERY DISEASE 3 YRS Due to (or as a consequence of): d. COPD 5 YRS | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA - 1985 ; ESOPHAGEAL ULCERS; CABG - 1997 | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  MD | | 29c. License number D28988 | | 29d. Date signed (Month, Day, Year) JULY 28, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA R. ARQUILLANO MD 3001 South Hanover St. Balt. MD 21225 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

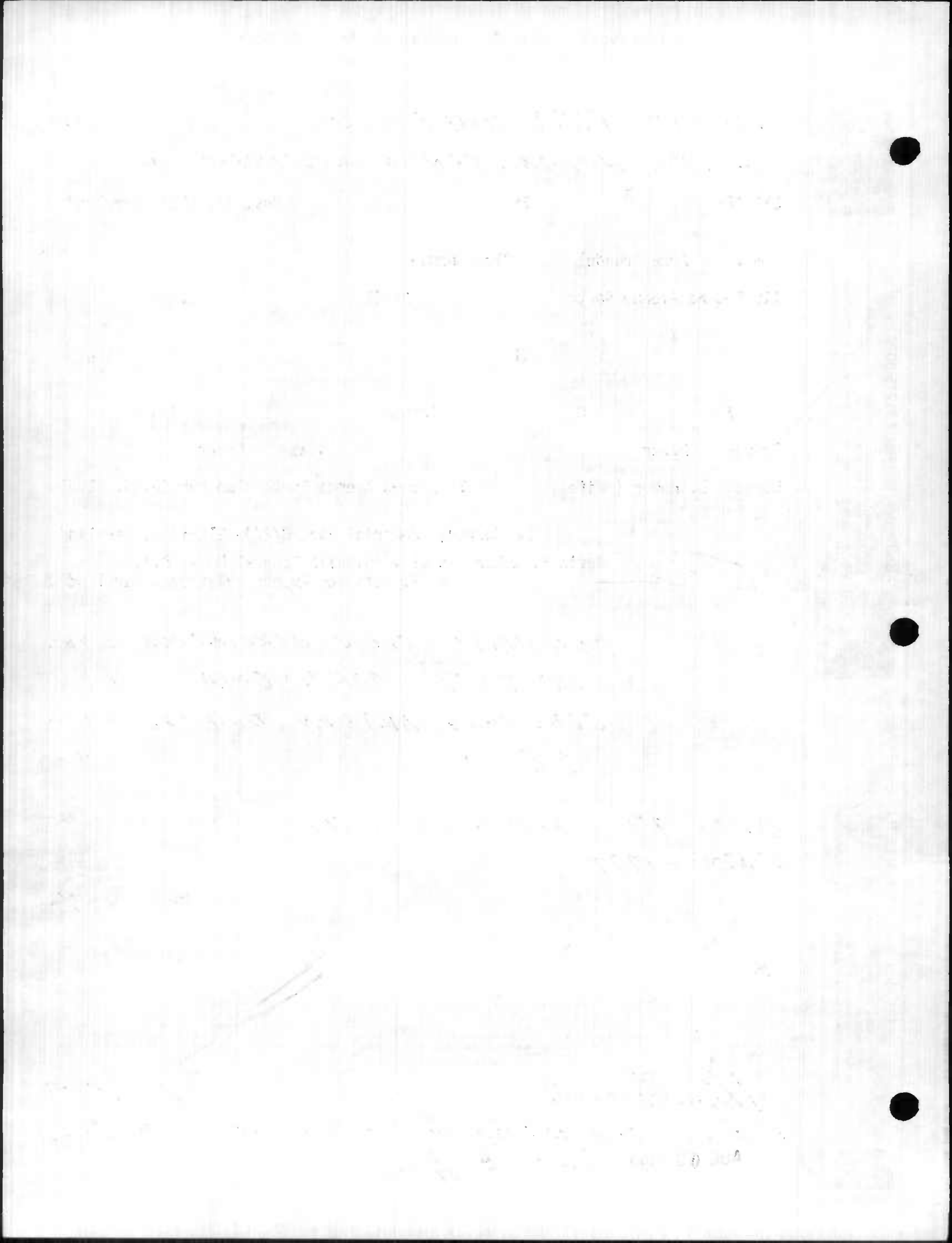
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24205

AMEND ITEM: #5 PER F.H. G774 8-13-99 WR.

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|---|--|--------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VERNA HANCOCK | | 2. Date of Death Month Day Year JULY 30 1999 | | 3. Time of Death 9:00AM |
| | 4a. Facility Name (If not Institution, give street and number) HARBOR HOSPITAL CENTER | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 409-30-3885 800-04-5114 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Feb. 7, 1913 | | 9. Birthplace (State or Foreign Country) Tennessee | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 3807 Brooklyn Avenue | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retail | | 16b. Kind of Business/Industry Hoschild-Kohn Company | | | |
| 17. Father's Name (First, Middle, Last) Samuel Lane | | | 18. Mother's Name (First, Middle, Maiden Sumama) Catherine Snapp | | |
| 19a. Informant's Name/Relationship (Type, Print) Herbert R. Hancock (Husband) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3807 Brooklyn Avenue Baltimore, Maryland 21225 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee Daniel A. Neph | | 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. GANGRENE OF RIGHT FOOT Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 DAYS 1 MONTH | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS HYPERTENSION | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier P. Patel M.D. | | 29c. License number P:11950 | | 29d. Date signed (Month, Day, Year) JULY 30 1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PIYUSH PATEL, HARBOR HOSPITAL CENTER, MD - 21225 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24206

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | |
|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last) BEULAH E HARDINGHAM | | 2. Date of Death Month August Day 2 Year 1999 | | 3. Time of Death 340 AM |
| 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore |
| 5. Social Security Number 212-30-4043 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | 8. Date of Birth (Month, Day, Year) Jan. 1, 1912 | 9. Birthplace (State or Foreign Country) Virginia |
| Usual Residence of Decedent | | | | |
| 10a. State Md. | 10b. County Baltimore | 10c. City, Town or Location Essex | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 414 South Marlyn Ave. | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress | | 16b. Kind of Business/Industry Resturant |
| 17. Father's Name (First, Middle, Last) William Strange | | 18. Mother's Name (First, Middle, Maiden Sumame) Minnie Caraco | | |
| 19a. Informant's Name/Relationship (Type, Print) William HARDingham/husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 South NArlyn Ave. Baltimore Md. 21221 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cemetery | | 20c. Location - City or Town, State 8/4/99 Owings Mills Md. |
| 21. Signature of Funeral Service Licensee R. Terry Connelly | | 22. Name and Address of Facility Connelly Funeral Home of Essex 300 MACE AVE. Baltimore Md. 21221 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Urosepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 1 week | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Savitha Shivananda MD | | |
| | | 29c. License number D 52379 | | 29d. Date signed (Month, Day, Year) August 2, 1999 |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Savitha Shivananda MD 9000 Franklin Square Drive Baltimore | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Apater | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24207

| | | | | | | | | |
|---|--|---|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie Harden | | | | 2. Date of Death Month Day Year July 31, 1999 | | 3. Time of Death 4:50 PM | |
| | 4a. Facility Name (If not institution, give street and number) Brightwood Center | | | | 4b. City, Town, or Location of Death Brooklandville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 214-05-3605 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) May 9, 1910 | |
| | 9. Birthplace (State or Foreign Country) Baltimore, MD | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Freeland | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 2520 Beckleysville Road | | 10f. Zip Code 21053 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | | |
| 17. Father's Name (First, Middle, Last) Frank Herold | | 18. Mother's Name (First, Middle, Maiden Surname) Sophie Hvalak | | 19a. Informant's Name/Relationship (Type, Print) Mary M. Iampieri/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2520 Beckleysville Road Freeland, MD 21053 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cemetery | | 20c. Date Aug. 4, 1999 | | 20d. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee  Bryan W. Clary | | 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Silent Arrhythmia Due to (or as a consequence of): Constrictive Heart Failure Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 15 mins years years | | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC Renal Failure Stroke Diabetes - 2 | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier  Medical Attending | | 29c. License number D17118 | | 29d. Date signed (Month, Day, Year) 8/2/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Schwartz MD 115 E. McFarlane Ave 21212 | | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

WRC
99-4429-510
ALBERT
HOWARD
AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 8-11-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Albert Leon Howard IV | | | | 2. Date of Death Month Day Year JULY 27, 1999 | | 3. Time of Death 7:10 PM. | | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 217-90-6735 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 31 Yrs. | | 8. Date of Birth (Month, Day, Year) 9-23-1967 | | |
| | 9. Birthplace (State or Foreign Country) Md | | 10a. State Md | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 2922 Rosalind Avenue | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U S A | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Various Jobs | | | | | |
| 17. Father's Name (First, Middle, Last) Albert Leon Howard, III | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maxine Sampson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Maxine Sampson Green- Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2922 Rosalind Avenue Baltimore, Md 21215 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Date 8-2-99 | | 20d. Location - City or Town, State Catonsville, Md | | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE ALCOHOL INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) 7-27-99 | | 28b. Time of Injury 6:36 P M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 28, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. K. KOSK 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature  | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4508-510

B.K.S

DANIEL HEINDL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24209

| | | | | | | | | |
|---|--|---|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DANIEL B. HEINDL | | | | 2. Date of Death Month Day Year AUG. 1, 1999 | | 3. Time of Death 0630 AM | |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 219-11-7293 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 17 Yrs. | | 8. Date of Birth (Month, Day, Year) May 3, 1982 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2820 KENTUCKY AVENUE | | 10f. Zip Code 21213 | | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) STUDENT | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry N/A | | |
| 17. Father's Name (First, Middle, Last) UNKNOWN | | 18. Mother's Name (First, Middle, Maiden Surname) JACLYNN HEINDL | | 19a. Informant's Name/Relationship (Type, Print) JACLYNN HEINDL/MOTHER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2820 KENTUCKY AVENUE, BALTIMORE, MARYLAND 21213 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MOST HOLY REDEEMER CEM. 8/4/99 | | 20c. Location - City or Town, State BALTIMORE, MD. | | 21. Signature of Funeral Service Licensee  | | |
| 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BRONCHOPNEUMONIA AND ANEMIA COMPLICATING ULCERATIVE COLITIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) found 7/25/99 | | 28b. Time of Injury found M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred unknown neglect due to failure to seek medical attention | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence found residence | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2820 Kentucky Avenue Baltimore, Md. | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier  | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUG. 2, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter P. Kohn 111 Penn Street, Baltimore, Maryland 21201 | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature  | | State Registrar | | DHMH 16 Rev 6/95 | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24210

| | | | | | | | | | | |
|--|---|---------------------------------|---|--|---|--|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Joseph Imwold, Sr. | | | | 2. Date of Death Month Day Year July 30, 1999 | | 3. Time of Death 3:20pm | | | |
| | 4a. Facility Name (If not institution, give street and number) Gilchrist Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | | |
| Funeral Director | 5. Social Security Number 218-12-2890 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 11, 1923 | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Perry Hall | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 9326 Pent Angel Way | | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? United States | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Wholesale Drug Representative | | | 16b. Kind of Business/Industry Pharmaceutical | | | | |
| | 17. Father's Name (First, Middle, Last) Harry E. Imwold, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Katherine M. Yehle | | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mrs. Mildred Imwold / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9326 Pent Angel Way Perry Hall, MD 21236 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | Date 8/2/99 | | 20c. Location - City or Town, State Towson, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Timothy Harman | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pancreatic cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Dld tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier Anthony Riley, MD | | | | 29c. License number D25205 | | 29d. Date signed (Month, Day, Year) July 30, 1999 | | | |
| | 30. Name and address of person who completed cause of death (item 23a) (Type, Print) W-A-Riley G-BMC 6701 N. Charles St. Balto. md 2120Y | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature Benjamin S. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24211

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

CLIFTON B. JONES

2. Date of Death

Month

Day

Year

7 28 1999

3. Time of Death

8:00 AM

4a. Facility Name (If not institution, give street and number)

3313 Walbrook Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

238-48-7896

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

7-10-1933

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3313 Walbrook Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year of Deles:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Unk

17. Father's Name (First, Middle, Last)

Carl Jones

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Daniels

19a. Informant's Name/Relationship (Type, Print)

Ernest Jones - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2140 N. Smallwood Street Baltimore, Md 21216

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

7-31-99

20c. Location - City or Town, State

Catonsville, Md

21. Signature of Funeral Service Licensee

Blady wanes

22. Name and Address of Facility

March F.H. West 21215
4300 Wabash Avenue Baltimore, Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

ONE DAY

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

5 YEARS

Due to (or as a consequence of):

c. HYPERTENSION

10 YEARS

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROSIS

SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

BOARDING

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

HOME

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Seth, M.D.

29c. License number

D 33407

29d. Date signed (Month, Day, Year)

7/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEEPAK SETH, 5411, OLD FREDERICK ROAD SUITE #15, BALTIMORE MD 21136

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

REPORT OF THE

ANNUAL MEETING OF THE
SOCIETY OF AMERICAN
ENTOMOLOGISTS
Held at the Hotel
Macdonald, Toronto,
Ontario, Canada,
September 1-5, 1914.
Published by the
Society of American
Entomologists,
1914.

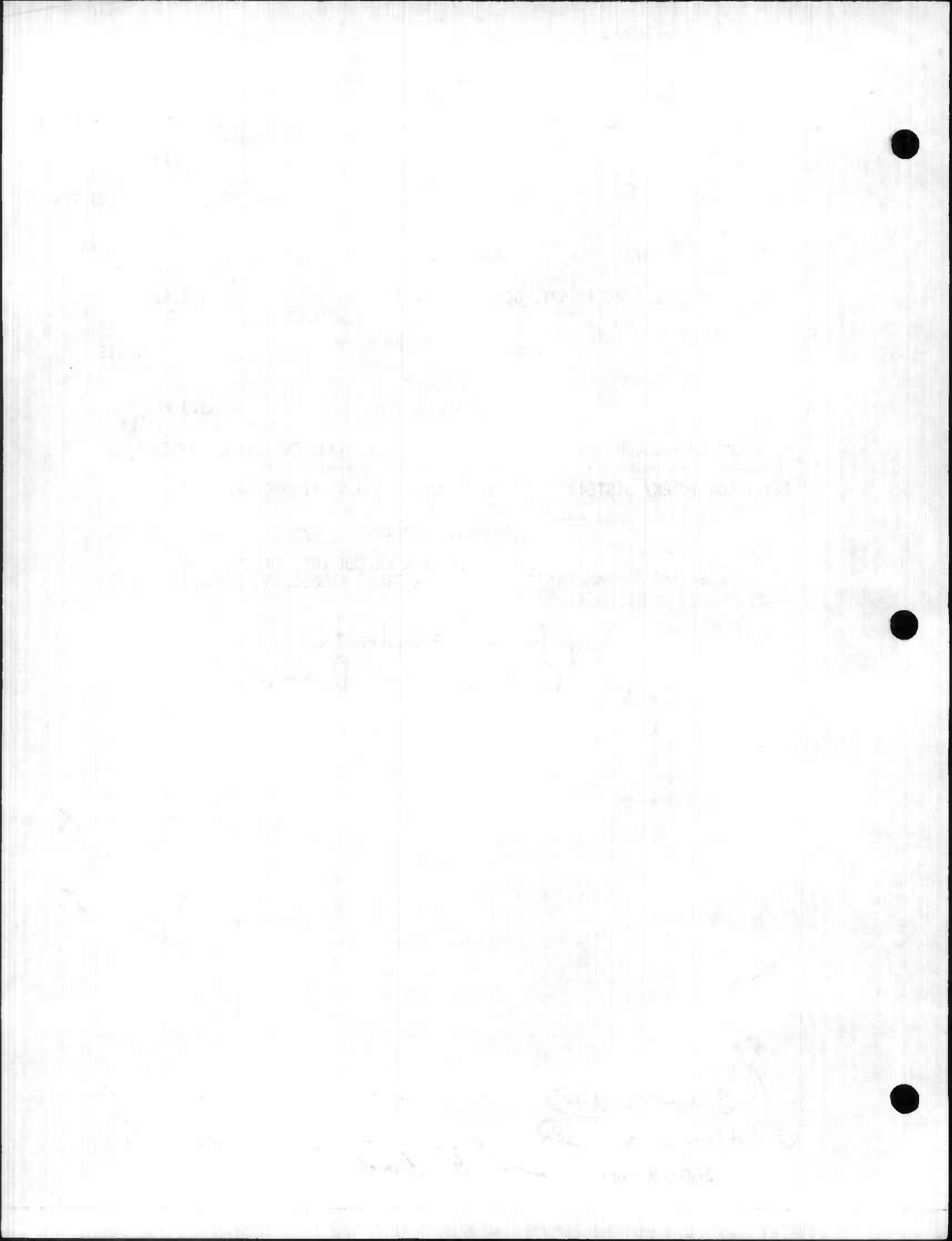
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|---|--|---|-----------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) RONALD WADE JOHNSON | | 2. Date of Death Month Day Year JULY 30, 1999 | | 3. Time of Death 13:29 PM | | | |
| 4a. Facility Name (If not institution, give street and number) 401 EAST 25th STREET | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| 5. Social Security Number 215-26-6552 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 23, 1928 | |
| 9. Birthplace (State or Foreign Country) W. VIRGINIA | | | | | | | |
| 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 401 EAST 25th STREET APT. 6C | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1950-54 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | | | 16b. Kind of Business/Industry AUTO PARTS | |
| 17. Father's Name (First, Middle, Last) JOSEPH EDWARD JOHNSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) NAOMI CATHERINE RHODEHEAVER | | | |
| 19a. Informant's Name/Relationship (Type, Print) BETTY LOU TUREK/ SISTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1688 POLES ROAD, BALTIMORE, MD. 21221 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY | | Date 8/2/99 | | 20c. Location - City or Town, State BALTIMORE, MD. | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier | |
| 29c. License number OCME | | 29d. Date signed (Month, Day, Year) JULY 31, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LaFon Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature | | | | | |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24213

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) NOAH TYRONE JOYCE 2. Date of Death Month July 07 Day 1999 Year 3. Time of Death 4:43 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center 4b. City, Town, or Location of Death Salisbury 4c. County of Death Wicomico

5. Social Security Number 220-66-4395 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) 42 Yrs. 8. Date of Birth (Month, Day, Year) August 5, 1956 9. Birthplace (State or Foreign Country) Salisbury, MD

Usual Residence of Decedent 10e. State Maryland 10b. County Wicomico 10c. City, Town or Location Eden 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 4131 Allen Road 10f. Zip Code 21822 10g. Citizen of What Country? USA

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) laborer 16b. Kind of Business/Industry Farming

17. Father's Name (First, Middle, Last) PAUL CHANDLER 18. Mother's Name (First, Middle, Maiden Surname) DELORES JOYCE

19a. Informant's Name/Relationship (Type, Print) Naushell Birckhead/sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6364 White Cove Dr. - Salisbury, Maryland 21801

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Friendship UM Church Cem. 20c. Location - City or Town, State 7/17/99 Allen Maryland

21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21801 JOLLEY MEMORIAL CHAPEL

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. GUNSHOT WOUND OF BACK OF CHEST Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☒ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ☒ Yes ☐ No

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☐ Natural ☐ Accident ☐ Suicide ☒ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of injury (Month, Day, Year) 7-7-99 28b. Time of injury UNK M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred SUBJECT WAS SHOT

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) STREET 28f. Location (Street and Number or Rural Route Number, City or Town, State) POPLAR STREET FRUITLAND, MARYLAND

29a. Certifier (Check only one) ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) JULY 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) AUG 03 1999 32. Registrar's Signature

Baltimore, Maryland 21215-0020

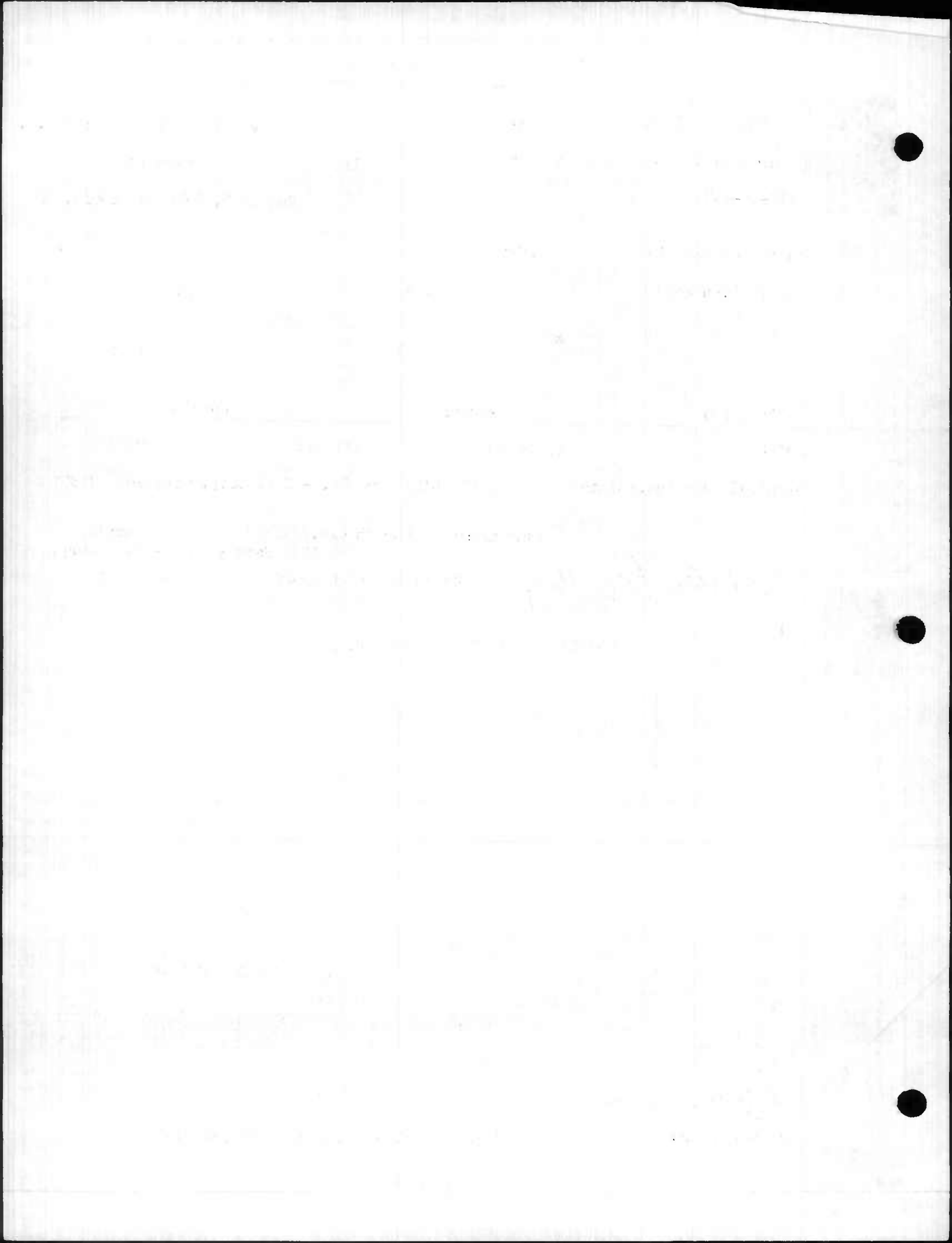
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24214

| | | | | | | | | |
|---|---|---------------------------|--|--|---|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CLARA JOYNER | | | | 2. Date of Death Month July Day 24 Year 1999 | | 3. Time of Death 6:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) Levindale Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 203-14-2847 | | 6. Sex 1 M | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 5, 1921 | |
| | 9. Birthplace (State or Foreign Country) Pa. | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 X Yes 2 No | |
| 10e. Street and Number 266 S. Monastery Avenue | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 3 X Widowed 4 Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Private Families | | |
| 17. Father's Name (First, Middle, Last) Romeo Briggs | | | | 18. Mother's Name (First, Middle, Maiden Summa) unknown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Wyman Joyner son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4311 Sihler Oaks Trail Owings Mills, Md. 21117 | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State July 29 Baltimore, Md. | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intracerebral hemorrhage Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | |
| Approximate Interval Between Onset and Death 37 days | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 Yes 2 X No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No | | |
| 25. Was case referred to medical examiner? 1 Yes 2 X No | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | | | 28a. Date of Injury (Month/Day/Year) N/A | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 X No |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | 29c. License number 015872 | | 29d. Date signed (Month, Day, Year) July 24, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harold B. B. 25 main st Rockville Md 20850 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1870-1871

1870-1871

1870-1871

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24215

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Alberta Kirsch | | | | 2. Date of Death Month July Day 31 Year 1999 | | 3. Time of Death 11:00am | | |
| | 4a. Facility Name (If not institution, give street and number) Keswick Multicare Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 213-20-9004 A | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 5, 1910 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 713 N. Kenwood Avenue | | | | 10f. Zip Code 21205 | | 10g. Citizen of What Country? U. S. A. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Musician | | 16b. Kind of Business/Industry Community College of Baltimore | | | | |
| | 17. Father's Name (First, Middle, Last) Rudolph Benesch | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Benesch | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Robert C. Wolf (Friend-POA) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3220 Lawnview Avenue, Baltimore, Maryland 21213 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hebrew Friendship Cemetery | | Date 8/2/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| | 21. Signature of Funeral Service Licensee Bruce C. Weller | | | | 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Carla Wolf Rosenthal MD | | 29c. License number D31025 | | 29d. Date signed (Month, Day, Year) August 1, 1999 | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carla Wolf Rosenthal MD 3333 North Calvert Street, Suite 325, Baltimore, Maryland 21218 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature James S. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24216

| | | | | | | | | | | | |
|---|---|---|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) George F. Keffer, Sr. | | | | 2. Date of Death Month Day Year JULY 31, 1999 | | | | 3. Time of Death 0615 AM | | |
| | 4a. Facility Name (If not institution, give street and number) WHITE MARSH MALL | | | | 4b. City, Town, or Location of Death WHITE MARSH | | | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 215-28-2775 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) May 7, 1931 | | 9. Birthplace (State or Foreign Country) Md. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Md | | 10b. County N/A | | 10c. City, Town or Location Baltimore, Md. | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 3025 Oakcrest Avenue | | | | 10f. Zip Code 21234 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: KOREAN | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Superintendent | | | | 16b. Kind of Business/Industry City of Baltimore | | | |
| 17. Father's Name (First, Middle, Last) Frank Keffer | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jennie Brandt | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) George F. Keffer, II | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Springtime Way, Baltimore, Md. 21234 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | Date 8/3/99 | | 20c. Location - City or Town, State Baltimore, Md. | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Hartley Miller Funeral Home, CHTD. 7527 Harford Rd. Baltimore, Md. 21234 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24e. Was an autopsy performed? Limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E | | | | 29d. Date signed (Month, Day, Year) JULY 31, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 11 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature  | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24217

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---|--|---------------------------------------|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Annie Lemon | | | | 2. Date of Death Month Day Year JULY 30, 1999 | | | | 3. Time of Death 0635 AM | |
| | 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL E.R. | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-92-2706 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) 03-23-04 | | 9. Birthplace (State or Foreign Country) SC | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 4915 Catalpha Road | | | | 10f. Zip Code 21214 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | | 16b. Kind of Business/Industry various trades | | |
| | 17. Father's Name (First, Middle, Last) Jim Lemon | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Brown | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Ella Vaughn | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4915 Catalpha Road Baltimore, Maryland 21214 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens | | Date 08-04-99 | | 20c. Location - City or Town, State Dundalk, MD | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March 1101 E. North Avenue | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| State Registrar | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? INSPECTION 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number O.C.M.E | | | | 29d. Date signed (Month, Day, Year) JULY 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24218

AMEND#8 PER F.H. G7748-3-99 J.A

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edna LEWIS | | | | 2. Date of Death Month 7 Day 29 Year 99 | | 3. Time of Death 10 AM | |
| | 4a. Facility Name (If not institution, give street and number) LEVINDALE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-36-9691 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) 1918 Aug. 3, 1999 | |
| | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3014 Wylie Ave. | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | 16b. Kind of Business/Industry Private Home | | | | |
| 17. Father's Name (First, Middle, Last) Thaddeus Burrell | | | | 18. Mother's Name (First, Middle, Maiden Surname) India Holiday | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Evelyn Montague (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5515 Peerless Ave. Balto. Md. 21207 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest | | 20c. Location - City or Town, State 8/5/99 Owings Mills, Md. | | | | |
| 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Recurrent Aspiration Pneumonia Due to (or as a consequence of): Dementia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular disease, Dysphasia, Asthma, COPD | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Juan M. Levy MD | | | | 29c. License number D33543 | | 29d. Date signed (Month, Day, Year) 7/29/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juan M. Levy MD Levindale | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Spaw | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24219

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ANTOINETTE LANASA

2. Date of Death

Month Day Year
JULY 29 1999

3. Time of Death

6 PM.

4a. Facility Name (If not institution, give street and number)

FUTURE CARE NORTH CHARLES HEALTH CARE CTR.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-32-6286

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 06 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

18 E. Cross Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sales person

16b. Kind of Business/Industry

Retail Dept. Store

17. Father's Name (First, Middle, Last)

Stefano Lanasa

18. Mother's Name (First, Middle, Maiden Surname)

Rosina Sansone

19a. Informant's Name/Relationship (Type, Print)

Josephine Uher (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 W. Conway Street Apt. 915 Baltimore, Md. 21201

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Cemetery

Date

7/31/99

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

David A. [Signature]

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.
130 E. Fort Ave., Baltimore, Md. 2123023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebral Thromboses

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

sudden

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

David A. [Signature]

29c. License number

D15872

29d. Date signed (Month, Day, Year)

July 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harold Bob and 25 Main St. Reisterstown 21136

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24220

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Roland S. Labatue

2. Date of Death

Month July Day 31 Year 1999

3. Time of Death

10:15PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health Care Center

4b. City, Town, or Location of Death

BelAir

4c. County of Death

Harford

5. Social Security Number

212-07-3961

8. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 10-30-1913

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10e. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2927 Pulaski Highway

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

West Va. Co., Co

17. Father's Name (First, Middle, Last)

Eugene Labatue

18. Mother's Name (First, Middle, Maiden Surname)

Julia Cassidy

19a. Informant's Name/Relationship (Type, Print)

Patricia Werner / Daughter 807 Foothill Ct. BelAir, Md. 21014

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Lawn Cemetery 8-4-99

Date

20c. Location - City or Town, State

Balto., Md.

21. Signature of Funeral Service Licensee

John M. Peters

22. Name and Address of Facility

Moran-Ashton-Dabrowski Funeral Home, Inc.

3000 E. Baltimore, St. Balto., Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Left Hemispheric Cerebrovascular Accident

Due to (or as a consequence of):

3 weeks.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John M. Peters

29c. License number

D35012

29d. Date signed (Month, Day, Year)

AUGUST 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Kevin Lynch 2 North Ave. Bel Air, Md. 21014.

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

John G. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Roland Labatue

9/4/10

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24221

| | | | | | | | | | |
|---|---|---|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CECIL MARTIN | | | | 2. Date of Death Month Day Year 7 30 99 | | 3. Time of Death 9:15 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Bon Secours Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death City | | |
| Funeral Director | 5. Social Security Number 213-07-4056 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth Month Day Year May 4, 1912 | 9. Birthplace (State or Foreign Country) North Carolina | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 1528 N. Monroe St. | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Afro-American | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver | | 16b. Kind of Business/Industry Taxi Co. | | | | |
| | 17. Father's Name (First, Middle, Last) James H. Martin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eliza Toney | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mrs. Shirley Pope (niece) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2326 Ashburton St. Balto. Md. 21216 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion | | 20c. Location - City or Town, State 8/7/99 Lansdowne, Md. | | Approximate Interval Between Onset and Death 15 minutes | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial FN Fibrillation Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier R. Adkins | | 29c. License number D0029868 | | 29d. Date signed (Month, Day, Year) July 31, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Adkins 2000 W. Baltimore St. Balto. Md. | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24222

| | | | | | |
|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Annie McBride</u> | | 2. Date of Death Month <u>7</u> Day <u>31</u> Year <u>99</u> | | 3. Time of Death <u>8:15 AM</u> |
| | 4e. Facility Name (If not institution, give street and number) <u>GOOD SAMARITAN HOSPITAL</u> | | 4b. City, Town, or Location of Death <u>BALTIMORE</u> | | 4c. County of Death |
| Funeral Director | 5. Social Security Number <u>099-20-6596</u> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>79</u> Yrs. | If Under 1 Year Montha Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <u>8-26-1919</u> | | 9. Birthplace (State or Foreign Country) <u>SC.</u> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State <u>MD.</u> | | 10b. County |
| | 10c. City, Town or Location <u>BALTIMORE</u> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number <u>501 E. PRESTON STREET</u> | | 10f. Zip Code <u>21202</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOMEMAKER</u> | | 16b. Kind of Business/Industry <u>HOME</u> | | |
| | 17. Father's Name (First, Middle, Last) <u>FRANK FURMAN</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>EMMA JOHNSON</u> | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>EMMA COTTON</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>441 E. 28th STREET BALTIMORE MARYLAND 21218</u> | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>DRUID RIDGE CEMETERY</u> | | 20c. Location - City or Town, State <u>8-6-99 BALTIMORE, MARYLAND</u> |
| | 21. Signature of Funeral Service Licensee <u>Carl U. Stief</u> | | 22. Name and Address of Facility <u>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MARYLAND 21217</u> | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>CARDIAC ARREST</u> Due to (or as a consequence of): b. <u>CORONARY ARTERY DISEASE</u> Due to (or as a consequence of): c. <u>PERIPHERAL VASCULAR DISEASE</u> Due to (or as a consequence of): d. <u>HYPERTENSION.</u> | | | | Approximate Interval Between Onset and Death |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier <u>VIPULKOMAR</u> | | 29c. License number <u>D52228</u> | | 29d. Date signed (Month, Day, Year) <u>7/31/99</u> |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>3007 E. NORTHERN PKWY BALTIMORE, MD 21214</u> | | | | |
| | State Registrar | 31. Date filed (Month, Day, Year) <u>AUG 03 1999</u> | | 32. Registrar's Signature <u>B. Sparks</u> | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24223

| | | | | | | | | |
|---|---|---|---|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marlyn Lee Miller | | | | 2. Date of Death Month Day Year July 29, 1999 | | 3. Time of Death 6:45am | |
| | 4a. Facility Name (If not institution, give street and number) 5 Hillbrook Court, apt. 104 | | | | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-32-7311 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 23, 1935 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Timonium | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 5 Hillbrook Court, apt. 104 | | | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Payroll Supervisor | | 16b. Kind of Business/Industry Government (Defense) | | | |
| | 17. Father's Name (First, Middle, Last) Charles Nemec | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred Kenleigh | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Alvin D. Miller/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Hillbrook Court, apt. 104, Timonium, MD 21093 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns. | | Date 7/31/99 | | 20c. Location - City or Town, State Timonium, Maryland | |
| | 21. Signature of Funeral Service Licensee Bryan W. Clary | | 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Lung Cancer | | | | | | | |
| | Approximate Interval Between Onset and Death 18 months | | | | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer | | | | Due to (or as a consequence of): | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Due to (or as a consequence of): | | | |
| | Due to (or as a consequence of): | | | | Due to (or as a consequence of): | | | |
| | Due to (or as a consequence of): | | | | Due to (or as a consequence of): | | | |
| | Due to (or as a consequence of): | | | | Due to (or as a consequence of): | | | |
| | Due to (or as a consequence of): | | | | Due to (or as a consequence of): | | | |
| | Due to (or as a consequence of): | | | | Due to (or as a consequence of): | | | |
| | Due to (or as a consequence of): | | | | Due to (or as a consequence of): | | | |
| | Due to (or as a consequence of): | | | | Due to (or as a consequence of): | | | |
| | Due to (or as a consequence of): | | | | Due to (or as a consequence of): | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Bryan Bohnner | | | | 29c. License number D0043489 | | 29d. Date signed (Month, Day, Year) July 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Bohnner, MD 6569 N. Charles St., suite 407, Baltimore, MD 21204 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature Brian B. Bohnner | | | | | |

ORIGINAL

99 24224

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

4743+1 moser, Jennings
Division of Vital Records, P.O. Box 68760,
DH

State
Registrar

[Faint, illegible handwritten text covering the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24225

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie R. McQuaid

2. Date of Death

Month Day Year
July 29 1999

3. Time of Death

2228

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

216-52-6260

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 8, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3419 N. Furnace Road

10f. Zip Code

21084

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Pivec

18. Mother's Name (First, Middle, Maiden Surname)

Rose Drda

19a. Informant's Name/Relationship (Type, Print)

Dennis E. McQuaid (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8017 Neighbors Avenue, Baltimore, MD 21237

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer

Date

8/2/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Bryan A. Weller

22. Name and Address of Facility

Schimunek Funeral Home, Inc. 9705 Belair Road

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction

Approximate Interval Between Onset and Death

12 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

10 years

Due to (or as a consequence of):

c. Hypertension

20 years

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Norman Gossner MD

29c. License number

D32288

29d. Date signed (Month, Day, Year)

August 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

104 Plumtree Road, Suite 110, Bel Air, Maryland 21015

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

Jenna B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24226

| | | | | | | | | | | | |
|--|--|--|---|--|--|---------------------------------|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Aretta M. Metzgar</i> | | | | 2. Date of Death Month Day Year <i>August 2 1999</i> | | | | 3. Time of Death <i>7:01 a.m.</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Fallston General Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Fallston</i> | | | | 4c. County of Death <i>Harford</i> | | |
| Funeral Director | 5. Social Security Number <i>168-14-6077</i> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>80</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Feb. 28, 1919</i> | | 9. Birthplace (State or Foreign Country) <i>Pennsylvania</i> | | |
| | Usual Residence of Decedent | | | | 10e. State <i>PA</i> | | | | 10b. County <i>Carbon</i> | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location <i>Palmerton</i> | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| | 10e. Street and Number <i>669 Princeton Avenue</i> | | | | 10f. Zip Code <i>18071</i> | | | | 10g. Citizen of What Country? <i>U.S.A.</i> | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Sewing Machine Operator</i> | | | | 16b. Kind of Business/Industry <i>Garment Industry</i> | | |
| | 17. Father's Name (First, Middle, Last) <i>Clarence Eck</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Persie Kuehner</i> | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <i>Richard O. Metzgar (son)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>303 Langley Ct., Belair, MD 21015</i> | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Sky-View Memorial Park</i> | | 20c. Date <i>8/6/99</i> | | 20d. Location - City or Town, State <i>Hometown, PA</i> | | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility <i>Schimunek Funeral Home, Inc. 9705 Belair Road, Baltimore, MD 21236</i> | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Chronic Obstructive Pulmonary Disease</i> Due to (or as a consequence of): b. <i>Coronary Artery Disease</i> Due to (or as a consequence of): c. <i>Parkinson's Disease</i> Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number <i>H40583</i> | | 29d. Date signed (Month, Day, Year) <i>8/2/99</i> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Stephen Smalldore 2021 Emmerton Rd Belair MD 21015</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 03 1999</i> | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

418 222

10/10/20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24227

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LINDA BETH McNEY | | | | 2. Date of Death Month Day Year July 30 1999 | | 3. Time of Death 7:00PM |
| | 4a. Facility Name (If not institution, give street and number) Dulaney Towson Nursing Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 217-62-7108 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | 8. Date of Birth (Month, Day, Year) June 1, 1953 | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Towson | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 111 West Road | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker | | 16b. Kind of Business/Industry State of Maryland | | |
| | 17. Father's Name (First, Middle, Last) Lester P Chacey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Dodson | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Charlotte E Lewis Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 Camberley Circle Towson Maryland 21204 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery | | Date 8/3/99 | 20c. Location - City or Town, State Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>Dennis Stephen Kenabo</i> | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE SCLEROSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier <i>Dr. B. Sparks</i> | | 29c. License number D52228 | | 29d. Date signed (Month, Day, Year) 7/31/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIPULKUMAR BHACODIYA, 3007, E. NORTHERN PKWY, BALTIMORE, MD 21214 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 02 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24228**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---------------------------|---|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Patricia A. Mann | | | | 2. Date of Death Month Day Year July 23, 1999 | | | | 3. Time of Death 11:30 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Genesis Eldercare Perring Parkway | | | | 4b. City, Town, or Location of Death Parkville | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 219-32-5253 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) July 4, 1935 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 3015 Harview Avenue | | | | 10f. Zip Code 21234 | | | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | | | 16b. Kind of Business/Industry Retail | | |
| 17. Father's Name (First, Middle, Last) Unknown Starr | | | | 18. Mother's Name (First, Middle, Maiden Summa) Unknown Unknown | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gloria E. Harris (Friend) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3329 Texas Avenue Baltimore, Maryland 21234 | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | | 20c. Location - City or Town, State 7/31/99 Towson Maryland | | | | |
| 21. Signature of Funeral Service Licensee Milton J. Knight Jr | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 month | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number D45475 | | | | 29d. Date signed (Month, Day, Year) 7/29/99 | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24229**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Edwin Nutwell Sr.

2. Date of Death

August 1 1999 4:38pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

307 Edgemere Drive

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

218-36-3060

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 13, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

307 Edgemere Drive

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Alphonso Nutwell

18. Mother's Name (First, Middle, Maiden Surname)

Julia Adella

19a. Informant's Name/Relationship (Type, Print)

Rosalie Nutwell (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

307 Edgemere Drive, Annapolis, MD 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodfield Cemetery

Date

08/04

20c. Location - City or Town, State

Galesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stroke
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMONTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41698

29d. Date signed (Month, Day, Year)

08/02/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN C. HAMILTON, MD 205 RIDGELY AVE; ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24230

Timothy J. Niziolek

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) TIMOTHY J. NIZIOLEK | | | | 2. Date of Death Month: July Day: 28 , Year: 1999 | | 3. Time of Death 2:29 PM | |
| | 4a. Facility Name (If not institution, give street and number) 895 south exit to 95 south | | | | 4b. City, Town, or Location of Death Elkridge | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 213-72-1048 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 41 Yrs. | | 8. Date of Birth (Month, Day, Year) APR 18, 1958 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County N/A | |
| To Be Completed by Funeral Director | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3232 O'DONNELL ST. | | 10f. Zip Code 21224 | |
| | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| To Be Completed by Physician/Medical Examiner | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | 16b. Kind of Business/Industry TRUCKING | |
| | 17. Father's Name (First, Middle, Last) JOSEPH P. NIZIOLEK | | 18. Mother's Name (First, Middle, Maiden Surname) PATRICIA LUCKHARDT | | 19a. Informant's Name/Relationship (Type, Print) JOSEPH P. NIZIOLEK | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2419 FLEET ST. BALTIMORE, MD. 21224 | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | 20c. Location - City or Town, State BALTO. CO. MD. | | 20d. Date JULY 30 1999 | |
| | 21. Signature of Funeral Service Licensee Phonny J. Skarda Jr. | | 22. Name and Address of Facility SKARDA FH. 2819 HUDSON ST. BALTO, MD. 21224 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Injuries | | Approximate Interval Between Onset and Death | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 7/28/99 | | 28b. Time of Injury 1422 M | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Driver in motor vehicle accident | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 1895 S 195 South | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier John Locke MD | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) July 29, 1999 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Locke MD | | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature P. Sparks | | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | |
| | 34. Date of Death (Month, Day, Year) AUG 03 1999 | | 35. Registrar's Signature P. Sparks | | 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | 37. Date of Death (Month, Day, Year) AUG 03 1999 | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AHB 43

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24231

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Gary Neville</u> | | | | 2. Date of Death Month <u>July</u> Day <u>31</u> Year <u>1999</u> | | 3. Time of Death <u>09:15 pm</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Geriatric Center</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>Baltimore City</u> | |
| Funeral Director | 5. Social Security Number <u>218-32-6983</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>62</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <u>Nov 25 1936</u> | 9. Birthplace (State or Foreign Country) <u>PA</u> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <u>MD</u> | | 10b. County <u>Baltimore</u> | | 10c. City, Town or Location <u>Baltimore</u> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number <u>7007 Baltimore St</u> | | | | 10f. Zip Code <u>21224</u> | | 10g. Citizen of What Country? <u>USA</u> | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Never Worked</u> | | 16b. Kind of Business/Industry <u>None</u> | | |
| 17. Father's Name (First, Middle, Last) <u>Frank L Neville Sr.</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Mabel Abbott</u> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Frank Neville Jr /brother</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7424 Poplar Ave Baltimore, MD 21224</u> | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory</u> | | Date <u>Aug 2 1999</u> | | 20c. Location - City or Town, State <u>Catonsville, MD</u> | | |
| 21. Signature of Funeral Service Licensee <u>Anthony C. Connelly</u> | | | | 22. Name and Address of Facility <u>Connolly Funeral Home of Dundalk</u> <u>7110 Sollers Point Rd 21222</u> | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Adenocarcinoma Lung</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Troussseau's Syndrome</u> <u>Chronic Obstructive Pulmonary Disease</u> | | | | Approximate Interval Between Onset and Death <u>one month</u> | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Pulmonary Embolus</u> <u>Troussseau's Syndrome</u> <u>Chronic Obstructive Pulmonary Disease</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>KP Kefferbarger MD</u> | | 29c. License number <u>5298</u> | | 29d. Date signed (Month, Day, Year) <u>August 1st, 1999</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>4940 Eastern Avenue Geriatric Center Baltimore, MD 21224</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 03 1999</u> | | 32. Registrar's Signature <u>Debra B. Smith</u> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24232

AMEND #7&8 PEE F.H. G774 8-3-99 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNIE OUTING

2. Date of Death
Month Day Year

AUGUST 1, 1999

3. Time of Death

8 52 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLS TOWN

4c. County of Death

BALTIMORE

5. Social Security Number

219-38-0798

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59 58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

1940 Dec. 10, 1946

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2410 Bibury Lane, #104

10f. Zip Code

21244

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Nursing/Highland Health Facility

17. Father's Name (First, Middle, Last)

Eddie Tankard

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Bailey

19a. Informant's Name/Relationship (Type, Print)

Thomas J. Outing, Sr., Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Lahinch Drive, Millersville, MD 21108

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

8/5/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

L. L. Holland

22. Name and Address of Facility

Loudon Park Funeral Home, 3620 Wilkens Avenue
Baltimore, Maryland 21229

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC ENCEPHALOPATHY
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, DIABETIS MELLITUS

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. L. Holland MD

29c. License number

D 19502

29d. Date signed (Month, Day, Year)

AUGUST 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORLANDO B. CONWAYAN MD

NORTHWEST HOSPITAL CENTER
RANDALLSTOWN MD. 21133

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1917

1917

1917

1917

1917

1917

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24233

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arlene Ogden

2. Date of Death
Month Day Year
AUGUST 02, 19993. Time of Death
01:45 AM

4a. Facility Name (If not institution, give street and number)

JOHN HOPKINS BAYVIEW

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

039-07-4280

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 8, 1921

9. Birthplace (State or Foreign Country)

RI

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1846 Marshall Rd

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles A. Hayhurst

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Holroyd

19a. Informant's Name/Relationship (Type, Print)

Willard Ogden /husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1846 Marshall Rd Baltimore, MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gardens of Faith

Date

Aug 4
1999

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk
7110 Sollers Point Rd 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?Inspection
1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician:2 ☒ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Stephen S. Radentz MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 02, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24234

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Corinne Peters

2. Date of Death

Month Day Year
July 25, 99

3. Time of Death

8:55pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sandtown Nursing & Rehab.Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

101-18-2324

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12-04-05

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10e. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1000 N. Gilmore Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Company

17. Father's Name (First, Middle, Last)

Jake White

18. Mother's Name (First, Middle, Maiden Surname)

Martha Unknown

19a. Informant's Name/Relationship (Type, Print)

Charlotte Elliott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

912 Wicklow Road Baltimore, Maryland 21229

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Woodlawn Cemetery 07-28-99

Date

20c. Location - City or Town, State

Woodlawn, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Multiple decubitus ulcers

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

Renal Failure

c. Due to (or as a consequence of):

Bilateral Hydronephrosis

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A-AHMED MD 821 N. Eutan Street Baltimore MD 21201

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State
Registrar

AUG 03 1999

Jenna B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

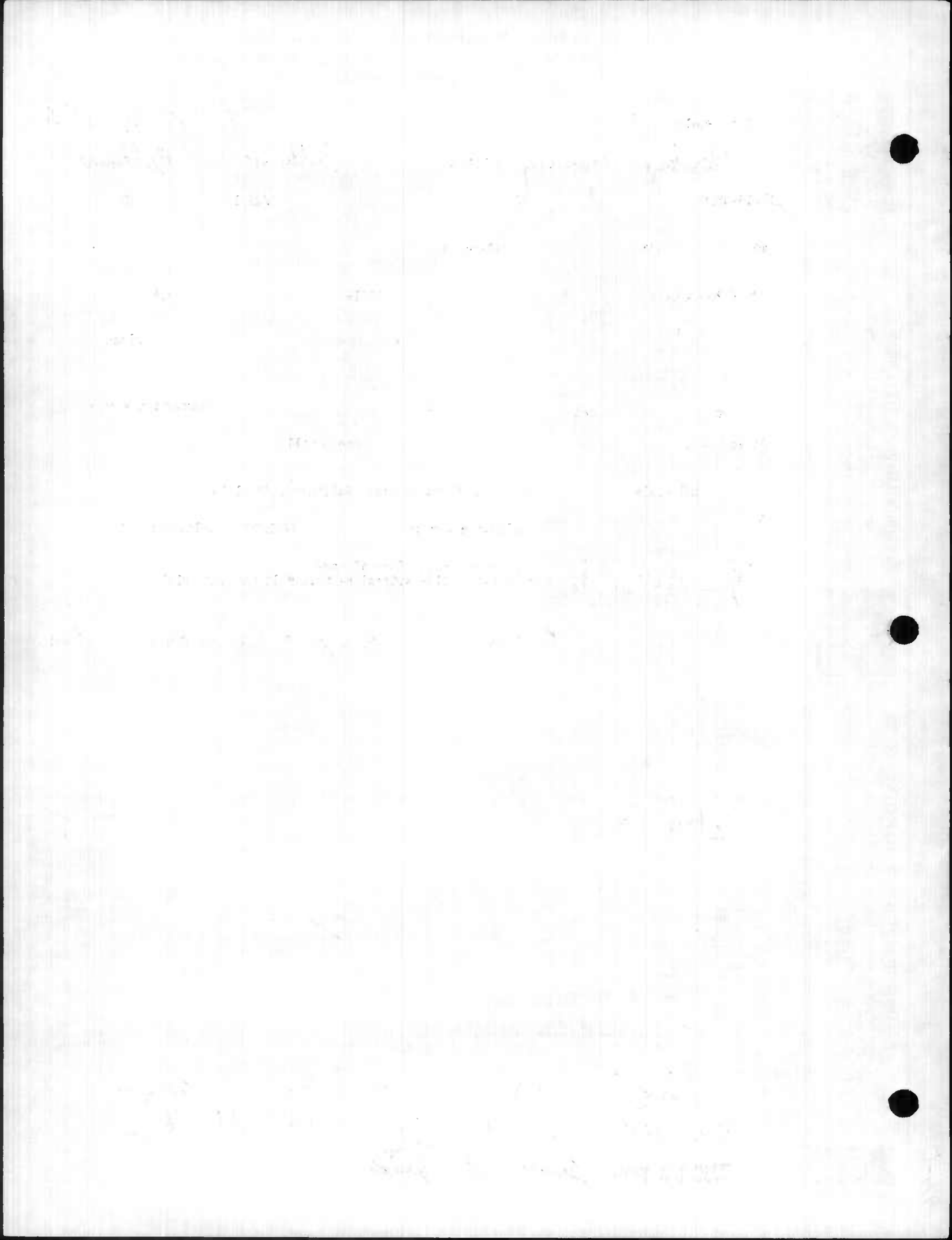
Reg. No.

99 24235

| | | | | | | | | | | | | | | | |
|--|---|--------------------|---|---|---|--|--|---|--|--|--|-------------------------------|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Emma Poole | | | | 2. Date of Death Month 7 Day 15 Year 99 | | | | 3. Time of Death 2:50 AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Heritage Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death Baltimore | | | | | | |
| Funeral Director | 5. Social Security Number 217-18-6355 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) 8/29/18 | | 9. Birthplace (State or Foreign Country) MD | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 10a. Street and Number 2527 Popes Lane | | | | 10f. Zip Code 21219 | | | | 10g. Citizen of What Country? USA | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook | | | | 16b. Kind of Business/Industry Restaurant Worker | | | | | | | |
| 17. Father's Name (First, Middle, Last) James Lewis | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Gill | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Paul Poole | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2527 Popes Lane, Baltimore, MD 21219 | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery | | | | Date 7/21/99 | | 20c. Location - City or Town, State Baltimore, MD | | | | | |
| 21. Signature of Funeral Service Licensee [Signature] | | | | | | 22. Name and Address of Facility Betts Funeral Home 1129 N. Caroline St., Baltimore, MD 21213 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Bronchiogenic Carcinoma Unknown Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Colon Ca | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier [Signature] | | 29c. License number D27569 | | 29d. Date signed (Month, Day, Year) 7/28/99 | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Allen Rottelman 1838 Greene Tree Rd #300 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24236

| | | | | | | | | |
|--|---|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Shirley A. Pribila | | | | 2. Date of Death Month Day Year August 01 1999 | | 3. Time of Death 10:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) 2916 Golden Fleece Drive | | | | 4b. City, Town, or Location of Death Pasadena | | 4c. County of Death Anne Arundel Co. | |
| Funeral Director | 5. Social Security Number 212-48-0260 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 50 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 03 1948 | |
| | 9. Birthplace (State or Foreign Country) West Virginia | | 10a. State Md. | | 10b. County Anne Arundel Co. | | 10c. City, Town or Location Pasadena | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 2916 Golden Fleece Drive | | 10f. Zip Code 21122 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) n/a | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Barber | | 16b. Kind of Business/Industry self-employed | | |
| 17. Father's Name (First, Middle, Last) Robert Lee Holleman | | | | 18. Mother's Name (First, Middle, Maiden Summa) Hazel Lucas | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ronald Holleman (Brother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2916 Golden Fleece Drive, Pasadena, Md. 21122 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | 20c. Location - City or Town, State 8/4/99 Glen Burnie, Md. | | 21. Signature of Funeral Service Licensee  | | |
| 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Non - Small cell lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 1 year | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  Elle Euron MD | | | | 29c. License number 00054145 | | 29d. Date signed (Month, Day, Year) August 2 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elle Euron MD 600 N. Wolfe St. Baltimore MD 21287 | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24237

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty M. Prince

2. Date of Death

Month Day Year
Aug. 1, 19993. Time of Death
9:15 A.M.

4a. Facility Name (If not institution, give street and number)

602 Laurel Drive

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

220-03-9529

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 27, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

602 Laurel Drive

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas D. Franklin

18. Mother's Name (First, Middle, Maiden Surname)

Thelma M. Brander

19a. Informant's Name/Relationship (Type, Print)

Donald R. Beall (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

602 Laurel Drive Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Pk.

Date

8/4/99

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.
3204 Mountain Road Pasadena, Maryland 21122

23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

years

c. Coronary Artery disease

Due to (or as a consequence of):

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19512

29d. Date signed (Month, Day, Year)

Aug 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDY C. D.H. M.D. 1600 Crain Hwy. Suite 206 Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

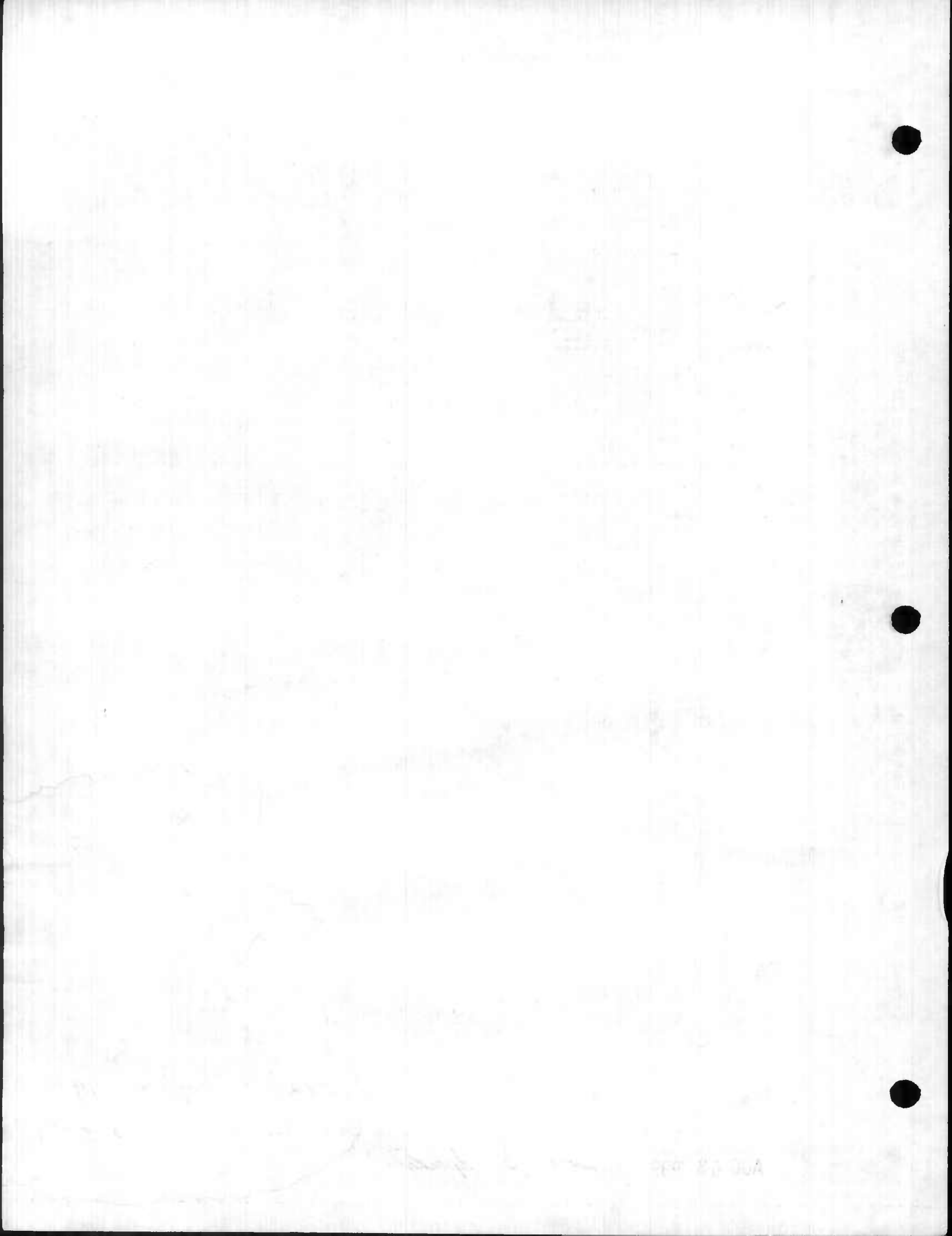
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24238

| | | | | | | | | |
|---|--|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Eva Gertrude Pollack (AKA Polak) | | | | 2. Date of Death Month Day Year July 25, 1999 | | 3. Time of Death 9:15 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Future Care Nursing Home | | | | 4b. City, Town, or Location of Death Arnold | | 4c. County of Death Anne Arundel Co. | |
| Funeral Director | 5. Social Security Number 216-01-9167 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | 8. Date of Birth (Month, Day, Year) Dec. 24, 1913 | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel Co. | | 10c. City, Town or Location Severna Park | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 436 Lynwood Drive | | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator | | 16b. Kind of Business/Industry Western Electric | | |
| 17. Father's Name (First, Middle, Last) Dominic Kasubinski | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lottie Pulaski | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Yvonne Johnson Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Roberts Road Newtown Square, Pennsylvania 19073 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery | | 20c. Date July 30, 1999 | | 20d. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave. Baltimore, Maryland 21225 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pneumonia Due to (or as a consequence of): advanced dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. history of major depression, recurrent coronary artery disease, atrial fibrillation, pacemaker, hypertension | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D41955 | | 29d. Date signed (Month, Day, Year) 7-29-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca Elton MD 479 Tumpers Hole Rd Severna Park MD 21146 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24239

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HATTIE PARKER

2. Date of Death
Month Day Year

07-29-99

3. Time of Death

845 PM

4a. Facility Name (If not institution, give street and number)

LEVINDALE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

215-30-5640

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9-15-1915

9. Birthplace (State or Foreign Country)

Va

Usual Residence of Decedent

10e. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5718 Narcissus Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5th

College (1-4 or 5+)

NA

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Home

17. Father's Name (First, Middle, Last)

George Finney

18. Mother's Name (First, Middle, Maiden Surname)

Betty Amos

19e. Informant's Name/Relationship (Type, Print)

Deborah Williams Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5718 Narcissus Avenue Balto, Md 21215

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

8-3-99

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

Stephen B. Harris

22. Name and Address of Facility

Mary F. A. West
4300 Wabash Avenue Balto, Md 21215

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. End stage congestive heart failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

76 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End stage chronic renal failure

Due to (or as a consequence of):

76 mo

c. Hypertension

Due to (or as a consequence of):

76 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen B. Harris MD

29c. License number

D44817

29d. Date signed (Month, Day, Year)

JULY 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amin P. Kojari, 2434 W. Schuette Ave, Baltimore

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

Stephen B. Sparks

State
RegistrarHATTIE PARKER
Baltimore, Maryland 21215-0020Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, R

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24240

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|-------------------------------|---|--|--|--------------------------------|--|---|-----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT J. ROBINSON | | | | 2. Date of Death Month 07 Day 30 Year 99 | | 3. Time of Death 0400 | | |
| | 4a. Facility Name (If not Institution, give street and number) BON SECOURS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 220-38-5901 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 56 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) OCT. 23 1942 | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 802 N. BENTALOU STREET | | | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA. | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSE KEEPER | | 16b. Kind of Business/Industry HOSPITAL | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) ROBERT ROBERTSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) VIOLA SIMMS | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) FLORENCE HIGGINS (COUSIN) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 N. BENTALOU ST., BALTIMORE, MD. 21216 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Location - City or Town, State AUG 4, 1999 LANSDOWNE, MARYLAND | | 20d. Date | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. HYPOTENSION Due to (or as a consequence of):</p> <p>b. HYPOGLYCEMIA Due to (or as a consequence of):</p> <p>c. SEPSIS Due to (or as a consequence of):</p> <p>d. END STAGE RENAL DISEASE</p> </div> </div> | | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier | | | | 29c. License number D42683 | | 29d. Date signed (Month, Day, Year) 07/30/1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RADCLIFFE TITOMAS MD 4000 W NORTHERN PKWY, BALTIMORE MD 21215 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24241**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward Richardsoo | | | | 2. Date of Death Month Day Year July 29 1999 | | 3. Time of Death 7:30 pm | |
| | 4a. Facility Name (If not institution, give street and number) VILLA ST. MICHAELS NURSING HOME | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 248-18-2107 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) APRIL 12, 1916 | |
| | 9. Birthplace (State or Foreign Country) SOUTH CAROLINA | | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | |
| To Be Completed by Funeral Director | 10e. Street and Number 4800 SETON DRIVE | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEELWORKER | | 16b. Kind of Business/Industry STEEL COMPANY | |
| | 17. Father's Name (First, Middle, Last) UNKNOWN | | | | 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN | | | |
| | 19a. Informant's Name/Relationship (Type, Print) CALVIN RICHARDSON (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1609 HOLBROOK ST., BALTIMORE, MD. 21202 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Date 8-3-99 | | 20d. Location - City or Town, State LANSOWNE, MARYLAND | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 3140 N. FULTON AVE., BALTIMORE, MD. 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE CORONARY THROMBOSIS Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number H45931 | | 29d. Date signed (Month, Day, Year) July 29, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DEBORAH PIERCE, 7220 PARK HEIGHTS AVE, BALTO. MD. 21208 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature | | | | |

Handwritten text at the top of the page, possibly a title or header.

Main body of handwritten text, appearing as a series of lines across the page. The text is very faint and mostly illegible due to the quality of the scan. It seems to be a continuous narrative or list of items.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24242

AMENDED ITEM #1 PER MD G774 8/6/99 AH

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM H BUHLMANN WILLIAM H BUHLMAN | | | | 2. Date of Death Month Day Year 07 31 99 | | 3. Time of Death 21:34 | |
| | 4a. Facility Name (If not institution, give street and number) ST AGNES HEALTHCARE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218 07 8205 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) 03/31/1914 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State Md | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 4800 Benson Avenue | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry | | | | |
| 17. Father's Name (First, Middle, Last) Louis Buhlmann | | | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara Fairinholt | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Elsie Cageby/Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 Heatherwood Road, Balto, Md. 21227 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Balto-Wash Crematory 8/3 | | 20c. Location - City or Town, State Laurel, Md. | | | | |
| 21. Signature of Funeral Service Licensee M. Marshall | | | | 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Ventricular arrhythmias Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death 10 hours | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. CAD Due to (or as a consequence of): | | | | | 20 years | |
| | | c. Due to (or as a consequence of): | | | | | | |
| | | d. Due to (or as a consequence of): | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier B. Sparks MD | | | | | | |
| | | 29c. License number D590 | | 29d. Date signed (Month, Day, Year) 07/31/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. BARIFI OPARE-ADDO 2502 W. PATAPSCO 2B BALTIMORE MD 21230 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2025.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24243

| | | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET W. REMKE | | | | 2. Date of Death Month Day Year July 31, 1999 | | | | 3. Time of Death 2:40 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) 2008 Gumtree Terrace | | | | 4b. City, Town, or Location of Death Bel Air | | | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 233-10-2163 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth Month Day Year Dec. 7, 1909 | | 9. Birthplace (State or Foreign Country) Ohio | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD. | | 10b. County Harford | | 10c. City, Town or Location Bel Air | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 2008 Gumtree Terrace | | | | 10f. Zip Code 21015 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 4 years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Register Nurse | | | | 16b. Kind of Business/Industry State of West Virginia | | |
| 17. Father's Name (First, Middle, Last) Thomas Williams | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Isabelle Johnson | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Linda R. Lemasters (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 Gumtree Terrace, Bel Air, MD. 21015 | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Stone Church Cemetery | | 20c. Date 8/4/99 | | 20d. Location - City or Town, State Elm Grove, W. VA. | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death > 1 year | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 028339 | | 29d. Date signed (Month, Day, Year) August 2 1999 | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) LINDA FWEICHT 161 E Wheel Road Bel Air MD 21015 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24244

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel Strong

2. Date of Death

July 29, 1999

3. Time of Death

11:43 PM

4a. Facility Name (If not institution, give street and number)

Genesis Long Green Nsg. Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

238-20-1746

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 22, 1920

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1102 Druid Hill Ave.

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

10 8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Baker

16b. Kind of Business/Industry

Bakery

17. Father's Name (First, Middle, Last)

Perry Strong

18. Mother's Name (First, Middle, Maiden Surname)

Peggy Lyles

19a. Informant's Name/Relationship (Type, Print)

Ms. Peggy Strong (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3705 Clarks Lane Balto. Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Star

20c. Location - City or Town, State

8/3/99 Catonsville, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of the Prostate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Degenerative Joint Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diarrhea

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature] MD

29c. License number

D 31464

29d. Date signed (Month, Day, Year)

7/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOAH A. HASHTMI, 821 N. Eutaw St Suite 308 Balt MD 21201

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

[Signature]

State
Registrar

Daniel Strong
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24245

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia M. Sauerwald

2. Date of Death

Month Day Year
July 30 1999

3. Time of Death

4:20 PM

4a. Facility Name (If not institution, give street and number)

CATonsville Commons Nursing Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218 14 1065

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 25, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6 Edmondson Ridge Rd.

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Food Server and Preparer

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Henry Wilson Tracy

18. Mother's Name (First, Middle, Maiden Surname)

Grace McKenzie

19a. Informant's Name/Relationship (Type, Print)

Nancy Stanton / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5002 Edmondson Ave., Baltimore, MD 21229

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 8/2/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ISCHEMIC HEART DISEASE

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YRS

YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

ANEMIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20333

29d. Date signed (Month, Day, Year)

8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. ZONICK 1838 WHEATREE RD PICESVILLE MD

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24246

CHARLES SMITH

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

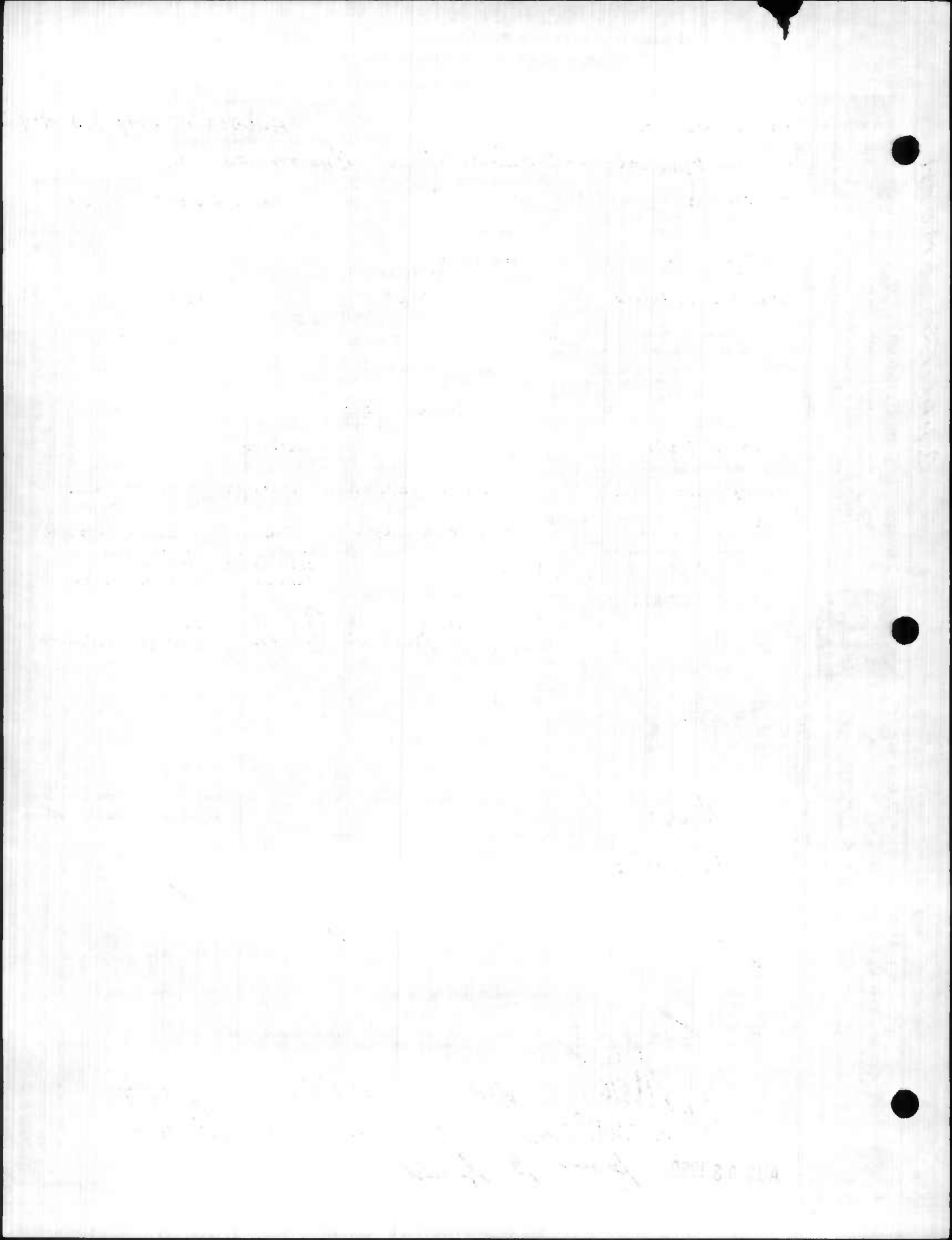
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | |
|---|--|---|---|---|---|--|--|--|
| Physician / Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles James Smith | | | | 2. Date of Death Month Day Year August 02, 1999 | | 3. Time of Death 7:00AM | |
| | 4a. Facility Name (If not institution, give street and number) CATON MANOR GENESIS ELDER CARE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 218-03-0641 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 18, 1907 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 3330 Wilkens Avenue | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) wallpaper hanger | | | 16b. Kind of Business/Industry home improvement | |
| 17. Father's Name (First, Middle, Last) Joseph T. Smith | | | | 18. Mother's Name (First, Middle, Maiden Summa) Mary Musgrove | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Audrey Smith - sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1218 Glyndon Avenue, Baltimore, Maryland 21223 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | Date 8/4/99 | | 20c. Location - City or Town, State Baltimore, Maryland |
| 21. Signature of Funeral Service Licensee Ann G. Zink | | | | 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 21229 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death Unknown |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspirin Dementia | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Allen Hoffman | | 29c. License number D21569 | | 29d. Date signed (Month, Day, Year) 8/2/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Hoffman 1838 Greene Tree Rd #300 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

443



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24247

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Staley

2. Date of Death

August 1, 1999

3. Time of Death

10:05 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Nursing Home

4b. City, Town, or Location of Death

Burtonsville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

280.16.8613

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 6, 1922

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7700 Cherry Lane

10f. Zip Code

20707

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Helen Uhlmann

19a. Informant's Name/Relationship (Type, Print)

Gary A. Staley/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4736 Ilkley Moor Ave. Ellicott City, Md. 21228

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hill

Date

8/6

20c. Location - City or Town, State

Caton, Ohio

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling-Ashton-Schwab

736 Edmondson Ave. Baltimore, Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24997

29d. Date signed (Month, Day, Year)

8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUIS A CASAS 8317 CHERRY LA, LAUREL, MD 20707

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24248

AMEND ITEM: #24A PER VERBAL RESPONSE G774 8-3-99 WR. **Certificate of Death**

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Garnette E Simpson | | 2. Date of Death Month 7 Day 1 Year 99 | | 3. Time of Death 1:20 AM | |
| 4a. Facility Name (If not institution, give street and number) 8 Judywood Lane | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore |
| 5. Social Security Number 213 342705 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| 8. Date of Birth (Month, Day, Year) 9-26-1920 | | 9. Birthplace (State or Foreign Country) W. Va. | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 8 Judywood Lane | | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Caucasian | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Collage (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Jerry Graham | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Linroe | | |
| 19a. Informant's Name/Relationship (Type, Print) April Montgomery/daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 815, Hedgesville, W. Va. 25427 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of the esophagus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death 1 month |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier William C. Stanley MD | | 29c. License number D17424 | | 29d. Date signed (Month, Day, Year) 7-26-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 S. Eutaw St. Suite 500 Baltimore MD 21201 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Handwritten text at the top of the page, possibly a title or header.

Handwritten text in the upper middle section.

Handwritten text in the middle section.

Handwritten text in the middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text in the lower middle section.

Handwritten text at the bottom of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---------------------------------|---|---|---|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward L. Shipley | | | | | 2. Date of Death Month 7 Day 29 Year 99 | | 3. Time of Death 8:40pm | |
| | 4a. Facility Name (If not institution, give street and number) Ridgeway Manor Nursing Home | | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 217-14-0845 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 11/24/1923 | | 9. Birthplace (State or Foreign Country) Md |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State Md | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 290 Bloomsbury | | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | 16b. Kind of Business/Industry Post Office | | |
| 17. Father's Name (First, Middle, Last) William Shipley | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Wortman | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Laurence Shipley/son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6026 Edmondson Avenue, Balto, Md. 21228 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | Date 8/2 | | 20c. Location - City or Town, State Baltimore, Md | | |
| 21. Signature of Funeral Service Licensee * Mark Marshall | | | | | 22. Name and Address of Facility Sterling Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228 | | | | |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Squamous cell carcinoma - lung. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Unknown | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease Cerebrovascular Accident, Hypertension Left lower extremity deep venous thrombosis | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier Michael Schwartz | | 29c. License number D19667 | | 29d. Date signed (Month, Day, Year) 7-30-99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MICHAEL SCHWARTZ 5517-A RITCHIE HWY, MD 21225 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | 32. Registrar's Signature B. Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24250

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET VIRGINIA STITZ

2. Date of Death

7 - 31 - 99

3. Time of Death

2:07 A.M.

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-12-3327

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

8-22-21

9. Birthplace (State or Foreign Country)

W. VA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3309 NORTHWAY DR.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WESTINGHOUSE

16b. Kind of Business/Industry

CLERICAL

17. Father's Name (First, Middle, Last)

FLOYD O. ROSS

18. Mother's Name (First, Middle, Maiden Summa)

CARRIE ALICE MYERS

19a. Informant's Name/Relationship (Type, Print)

THOMAS R. STITZ (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3309 NORTHWAY DR. BALTO. MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH

Date

8-3-99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Robert E. Ottendinger, Lic. Decedent

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.

6009 HARFORD RD BALTO. MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Exsanguination from

ruptured abdominal aortic aneurysm

Approximate Interval Between Onset and Death

30'

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicida4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shore & Jandele M.D.

29c. License number

D43936

29d. Date signed (Month, Day, Year)

8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS F. LANSDALE III, M.D. 6565 N. Charles St., Baltimore, MD 21204

State Registrar

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24251

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Geraldine C. Strempek | | | | 2. Date of Death Month 07 Day 17 Year 1999 | | 3. Time of Death 10:20am | |
| | 4a. Facility Name (If not institution, give street and number) 3314 Northway Drive | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore City | |
| Funeral Director | 5. Social Security Number 219-28-9869 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) April 1, 1933 | |
| | 9. Birthplace (State or Foreign Country) Baltimore City, MD | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3314 Northway Drive | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | 16b. Kind of Business/Industry Auction-Antiques | | | | |
| 17. Father's Name (First, Middle, Last) Elmer William Schweiger | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Schech | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Franklin M. Strempek - Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3314 Northway Drive, Baltimore, Maryland 21234 | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | Date 7/19/99 | | 20c. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road, Baltimore, MD 21236-4625 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary Arrest Due to (or as a consequence of): b. Increased Intracranial Pressure Due to (or as a consequence of): c. Brain Tumor and Hemorrhage Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D30060 | | 29d. Date signed (Month, Day, Year) 7/27/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reginald Davis, M.D., 6569 N. Charles St., Suite 403, Baltimore, MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24252

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herman Sippel

2. Date of Death

Month
JulyDay
31Year
1999

3. Time of Death

1:36 p.m.

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-20-8449

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
April 26, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

925 Malden Road

10f. Zip Code

21239

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1944-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (14 or 5+)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fire Fighter

16b. Kind of Business/Industry

Baltimore City Fire Department

17. Father's Name (First, Middle, Last)

Edward Sippel

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Staff

19a. Informant's Name/Relationship (Type, Print)

Margaret E. Sippel / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

925 Malden Road Baltimore, MD 21239

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

8/2/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee Timothy Harman

Timothy Harman

22. Name and Address of Facility

Leonard J. Ruck, Inc. Funeral Home
5305 Harford Road Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subarachnoid Hemorrhage

Due to (or as a consequence of):

2 days

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Traumatic Closed Head Injury

Due to (or as a consequence of):

3 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

APPROVED BY MEDICAL EXAMINER

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

July 29, 1999

28b. Time of Injury

12:15 p.m.

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

10 foot fall off ladder/scaffolding

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

925 Malden Road, Baltimore, MD

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tim P. Fitton, M.D.

29c. License number

PAS # 08761

29d. Date signed (Month, Day, Year)

July 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TORIN P. FITTON, M.D.

Sinai Hospital of Baltimore, Baltimore, MD.

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

S. Sparks

State
Registrar

Patient known as Herman Sippel

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AUG 03 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24253

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nicholas John Sfakianos

2. Date of Death

Month
July

Day

31

Year

1999

3. Time of Death

6:00PM

4a. Facility Name (If not institution, give street and number)

6 Elphin Court #202

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-22-1269

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 24 1924

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 Elphin Court #202

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Director Of Personnel

16b. Kind of Business/Industry

H&S Bakery

17. Father's Name (First, Middle, Last)

John Nicholas Sfakianos

18. Mother's Name (First, Middle, Maiden Surname)

Germain Girard

19a. Informant's Name/Relationship (Type, Print)

Mrs. Despo P. Sfakianos

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Elphin Court #202 Timonium, MD. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Cemetery

Date

8-3-99

20c. Location - City or Town, State

Timonium, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Ruck Towson Funeral Home, Inc
1050 York Rd. Towson, MD. 21204

23a. Pertinent diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

Prostate Cancer

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

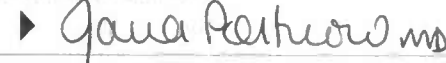
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D0053856

29d. Date signed (Month, Day, Year)

8/2/99

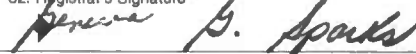
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Johns Hopkins Oncology Center, 600 N. Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24254

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Amelia Sandra Sienkielewski

2. Date of Death

Month Day Year
July 30, 1999

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

1 Lochmoor Court

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore Co.

Funeral
Director

5. Social Security Number

213-32-5968

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 21 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Lutherville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1 Lochmoor Court

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Samuel Serio

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Serio

19a. Informant's Name/Relationship (Type, Print)

Mr. Ramon Sienkielewski/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Lochmoor Court Lutherville, MD, 21093

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☒ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Woodlawn Cemetery

Date

8-2-99

20c. Location - City or Town, State

Woodlawn, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC CARCINOMA OF THE LUNG

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D34124

29d. Date signed (Month, Day, Year)

7-30-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. John Milto 1205 York Road Lutherville, Maryland 21093

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

Geneva B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician
/Medical
ExaminerFuneral
DirectorState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #10C, E, F 6775 9-17-99 WR.

AMEND ITEMS: # 19A, 18 PER F.H. 6774 8-19-99 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24255

| | | | | | | | | | | |
|---|---|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lineta M. Sparks | | | | 2. Date of Death Month July Day 29 Year 1999 | | | | 3. Time of Death 6:26 AM | |
| | 4a. Facility Name (If not institution, give street and number) Hillside House Assisted Living | | | | 4b. City, Town, or Location of Death Clarksville | | | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 227-64-9831 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 100 Yrs. | | 8. Date of Birth (Month, Day, Year) 1-29-1899 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location OLNEY Silver Spring | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 17009 NORBROOK DR. 11802 College View Drive | | | | 10f. Zip Code 20902 20832 | | | | 10g. Citizen of What Country? U. S. A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fiscal Acct. Clerk | | | | 16b. Kind of Business/Industry Norfolk Naval Yard | | |
| 17. Father's Name (First, Middle, Last) William Shepherd Morris | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lineta Belle Caples CAPLES | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ELISABETH L. BUBEL Elizabeth L. Bubel (Niece) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11802 College View Drive, Silver Spring, Md. 20902 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Hill Cemetery | | 20c. Location - City or Town, State 7-31-99 Towson, Maryland | | | | |
| 21. Signature of Funeral Service Licensee Wallace S. Brooks, Jr. | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 | | | | | | |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. INANITION ALZHEIMER'S DEMENTIAS | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | Approximate Interval Between Onset and Death Weeks Years | | |
| 23c. Due to (or as a consequence of): | | | | 23d. Due to (or as a consequence of): | | | | | | |
| 23e. Due to (or as a consequence of): | | | | 23f. Due to (or as a consequence of): | | | | | | |
| 23g. Due to (or as a consequence of): | | | | 23h. Due to (or as a consequence of): | | | | | | |
| 23i. Due to (or as a consequence of): | | | | 23j. Due to (or as a consequence of): | | | | | | |
| 23k. Due to (or as a consequence of): | | | | 23l. Due to (or as a consequence of): | | | | | | |
| 23m. Due to (or as a consequence of): | | | | 23n. Due to (or as a consequence of): | | | | | | |
| 23o. Due to (or as a consequence of): | | | | 23p. Due to (or as a consequence of): | | | | | | |
| 23q. Due to (or as a consequence of): | | | | 23r. Due to (or as a consequence of): | | | | | | |
| 23s. Due to (or as a consequence of): | | | | 23t. Due to (or as a consequence of): | | | | | | |
| 23u. Due to (or as a consequence of): | | | | 23v. Due to (or as a consequence of): | | | | | | |
| 23v. Due to (or as a consequence of): | | | | 23w. Due to (or as a consequence of): | | | | | | |
| 23w. Due to (or as a consequence of): | | | | 23x. Due to (or as a consequence of): | | | | | | |
| 23x. Due to (or as a consequence of): | | | | 23y. Due to (or as a consequence of): | | | | | | |
| 23y. Due to (or as a consequence of): | | | | 23z. Due to (or as a consequence of): | | | | | | |
| 23z. Due to (or as a consequence of): | | | | 23aa. Due to (or as a consequence of): | | | | | | |
| 23aa. Due to (or as a consequence of): | | | | 23ab. Due to (or as a consequence of): | | | | | | |
| 23ab. Due to (or as a consequence of): | | | | 23ac. Due to (or as a consequence of): | | | | | | |
| 23ac. Due to (or as a consequence of): | | | | 23ad. Due to (or as a consequence of): | | | | | | |
| 23ad. Due to (or as a consequence of): | | | | 23ae. Due to (or as a consequence of): | | | | | | |
| 23ae. Due to (or as a consequence of): | | | | 23af. Due to (or as a consequence of): | | | | | | |
| 23af. Due to (or as a consequence of): | | | | 23ag. Due to (or as a consequence of): | | | | | | |
| 23ag. Due to (or as a consequence of): | | | | 23ah. Due to (or as a consequence of): | | | | | | |
| 23ah. Due to (or as a consequence of): | | | | 23ai. Due to (or as a consequence of): | | | | | | |
| 23ai. Due to (or as a consequence of): | | | | 23aj. Due to (or as a consequence of): | | | | | | |
| 23aj. Due to (or as a consequence of): | | | | 23ak. Due to (or as a consequence of): | | | | | | |
| 23ak. Due to (or as a consequence of): | | | | 23al. Due to (or as a consequence of): | | | | | | |
| 23al. Due to (or as a consequence of): | | | | 23am. Due to (or as a consequence of): | | | | | | |
| 23am. Due to (or as a consequence of): | | | | 23an. Due to (or as a consequence of): | | | | | | |
| 23an. Due to (or as a consequence of): | | | | 23ao. Due to (or as a consequence of): | | | | | | |
| 23ao. Due to (or as a consequence of): | | | | 23ap. Due to (or as a consequence of): | | | | | | |
| 23ap. Due to (or as a consequence of): | | | | 23aq. Due to (or as a consequence of): | | | | | | |
| 23aq. Due to (or as a consequence of): | | | | 23ar. Due to (or as a consequence of): | | | | | | |
| 23ar. Due to (or as a consequence of): | | | | 23as. Due to (or as a consequence of): | | | | | | |
| 23as. Due to (or as a consequence of): | | | | 23at. Due to (or as a consequence of): | | | | | | |
| 23at. Due to (or as a consequence of): | | | | 23au. Due to (or as a consequence of): | | | | | | |
| 23au. Due to (or as a consequence of): | | | | 23av. Due to (or as a consequence of): | | | | | | |
| 23av. Due to (or as a consequence of): | | | | 23aw. Due to (or as a consequence of): | | | | | | |
| 23aw. Due to (or as a consequence of): | | | | 23ax. Due to (or as a consequence of): | | | | | | |
| 23ax. Due to (or as a consequence of): | | | | 23ay. Due to (or as a consequence of): | | | | | | |
| 23ay. Due to (or as a consequence of): | | | | 23az. Due to (or as a consequence of): | | | | | | |
| 23az. Due to (or as a consequence of): | | | | 23ba. Due to (or as a consequence of): | | | | | | |
| 23ba. Due to (or as a consequence of): | | | | 23bb. Due to (or as a consequence of): | | | | | | |
| 23bb. Due to (or as a consequence of): | | | | 23bc. Due to (or as a consequence of): | | | | | | |
| 23bc. Due to (or as a consequence of): | | | | 23bd. Due to (or as a consequence of): | | | | | | |
| 23bd. Due to (or as a consequence of): | | | | 23be. Due to (or as a consequence of): | | | | | | |
| 23be. Due to (or as a consequence of): | | | | 23bf. Due to (or as a consequence of): | | | | | | |
| 23bf. Due to (or as a consequence of): | | | | 23bg. Due to (or as a consequence of): | | | | | | |
| 23bg. Due to (or as a consequence of): | | | | 23bh. Due to (or as a consequence of): | | | | | | |
| 23bh. Due to (or as a consequence of): | | | | 23bi. Due to (or as a consequence of): | | | | | | |
| 23bi. Due to (or as a consequence of): | | | | 23bj. Due to (or as a consequence of): | | | | | | |
| 23bj. Due to (or as a consequence of): | | | | 23bk. Due to (or as a consequence of): | | | | | | |
| 23bk. Due to (or as a consequence of): | | | | 23bl. Due to (or as a consequence of): | | | | | | |
| 23bl. Due to (or as a consequence of): | | | | 23bm. Due to (or as a consequence of): | | | | | | |
| 23bm. Due to (or as a consequence of): | | | | 23bn. Due to (or as a consequence of): | | | | | | |
| 23bn. Due to (or as a consequence of): | | | | 23bo. Due to (or as a consequence of): | | | | | | |
| 23bo. Due to (or as a consequence of): | | | | 23bp. Due to (or as a consequence of): | | | | | | |
| 23bp. Due to (or as a consequence of): | | | | 23bq. Due to (or as a consequence of): | | | | | | |
| 23bq. Due to (or as a consequence of): | | | | 23br. Due to (or as a consequence of): | | | | | | |
| 23br. Due to (or as a consequence of): | | | | 23bs. Due to (or as a consequence of): | | | | | | |
| 23bs. Due to (or as a consequence of): | | | | 23bt. Due to (or as a consequence of): | | | | | | |
| 23bt. Due to (or as a consequence of): | | | | 23bu. Due to (or as a consequence of): | | | | | | |
| 23bu. Due to (or as a consequence of): | | | | 23bv. Due to (or as a consequence of): | | | | | | |
| 23bv. Due to (or as a consequence of): | | | | 23bw. Due to (or as a consequence of): | | | | | | |
| 23bw. Due to (or as a consequence of): | | | | 23bx. Due to (or as a consequence of): | | | | | | |
| 23bx. Due to (or as a consequence of): | | | | 23by. Due to (or as a consequence of): | | | | | | |
| 23by. Due to (or as a consequence of): | | | | 23bz. Due to (or as a consequence of): | | | | | | |
| 23bz. Due to (or as a consequence of): | | | | 23ca. Due to (or as a consequence of): | | | | | | |
| 23ca. Due to (or as a consequence of): | | | | 23cb. Due to (or as a consequence of): | | | | | | |
| 23cb. Due to (or as a consequence of): | | | | 23cc. Due to (or as a consequence of): | | | | | | |
| 23cc. Due to (or as a consequence of): | | | | 23cd. Due to (or as a consequence of): | | | | | | |
| 23cd. Due to (or as a consequence of): | | | | 23ce. Due to (or as a consequence of): | | | | | | |
| 23ce. Due to (or as a consequence of): | | | | 23cf. Due to (or as a consequence of): | | | | | | |
| 23cf. Due to (or as a consequence of): | | | | 23cg. Due to (or as a consequence of): | | | | | | |
| 23cg. Due to (or as a consequence of): | | | | 23ch. Due to (or as a consequence of): | | | | | | |
| 23ch. Due to (or as a consequence of): | | | | 23ci. Due to (or as a consequence of): | | | | | | |
| 23ci. Due to (or as a consequence of): | | | | 23cj. Due to (or as a consequence of): | | | | | | |
| 23cj. Due to (or as a consequence of): | | | | 23ck. Due to (or as a consequence of): | | | | | | |
| 23ck. Due to (or as a consequence of): | | | | 23cl. Due to (or as a consequence of): | | | | | | |
| 23cl. Due to (or as a consequence of): | | | | 23cm. Due to (or as a consequence of): | | | | | | |
| 23cm. Due to (or as a consequence of): | | | | 23cn. Due to (or as a consequence of): | | | | | | |
| 23cn. Due to (or as a consequence of): | | | | 23co. Due to (or as a consequence of): | | | | | | |
| 23co. Due to (or as a consequence of): | | | | 23cp. Due to (or as a consequence of): | | | | | | |
| 23cp. Due to (or as a consequence of): | | | | 23cq. Due to (or as a consequence of): | | | | | | |
| 23cq. Due to (or as a consequence of): | | | | 23cr. Due to (or as a consequence of): | | | | | | |
| 23cr. Due to (or as a consequence of): | | | | 23cs. Due to (or as a consequence of): | | | | | | |
| 23cs. Due to (or as a consequence of): | | | | 23ct. Due to (or as a consequence of): | | | | | | |
| 23ct. Due to (or as a consequence of): | | | | 23cu. Due to (or as a consequence of): | | | | | | |
| 23cu. Due to (or as a consequence of): | | | | 23cv. Due to (or as a consequence of): | | | | | | |
| 23cv. Due to (or as a consequence of): | | | | 23cw. Due to (or as a consequence of): | | | | | | |
| 23cw. Due to (or as a consequence of): | | | | 23cx. Due to (or as a consequence of): | | | | | | |
| 23cx. Due to (or as a consequence of): | | | | 23cy. Due to (or as a consequence of): | | | | | | |
| 23cy. Due to (or as a consequence of): | | | | 23cz. Due to (or as a consequence of): | | | | | | |
| 23cz. Due to (or as a consequence of): | | | | 23da. Due to (or as a consequence of): | | | | | | |
| 23da. Due to (or as a consequence of): | | | | 23db. Due to (or as a consequence of): | | | | | | |
| 23db. Due to (or as a consequence of): | | | | 23dc. Due to (or as a consequence of): | | | | | | |
| 23dc. Due to (or as a consequence of): | | | | 23dd. Due to (or as a consequence of): | | | | | | |
| 23dd. Due to (or as a consequence of): | | | | 23de. Due to (or as a consequence of): | | | | | | |
| 23de. Due to (or as a consequence of): | | | | 23df. Due to (or as a consequence of): | | | | | | |
| 23df. Due to (or as a consequence of): | | | | 23dg. Due to (or as a consequence of): | | | | | | |
| 23dg. Due to (or as a consequence of): | | | | 23dh. Due to (or as a consequence of): | | | | | | |
| 23dh. Due to (or as a consequence of): | | | | 23di. Due to (or as a consequence of): | | | | | | |
| 23di. Due to (or as a consequence of): | | | | 23dj. Due to (or as a consequence of): | | | | | | |
| 23dj. Due to (or as a consequence of): | | | | 23dk. Due to (or as a consequence of): | | | | | | |
| 23dk. Due to (or as a consequence of): | | | | 23dl. Due to (or as a consequence of): | | | | | | |
| 23dl. Due to (or as a consequence of): | | | | 23dm. Due to (or as a consequence of): | | | | | | |
| 23dm. Due to (or as a consequence of): | | | | 23dn. Due to (or as a consequence of): | | | | | | |
| 23dn. Due to (or as a consequence of): | | | | 23do. Due to (or as a consequence of): | | | | | | |
| 23do. Due to (or as a consequence of): | | | | 23dp. Due to (or as a consequence of): | | | | | | |
| 23dp. Due to (or as a consequence of): | | | | 23dq. Due to (or as a consequence of): | | | | | | |
| 23dq. Due to (or as a consequence of): | | | | 23dr. Due to (or as a consequence of): | | | | | | |
| 23dr. Due to (or as a consequence of): | | | | 23ds. Due to (or as a consequence of): | | | | | | |
| 23ds. Due to (or as a consequence of): | | | | 23dt. Due to (or as a consequence of): | | | | | | |
| 23dt. Due to (or as a consequence of): | | | | 23du. Due to (or as a consequence of): | | | | | | |
| 23du. Due to (or as a consequence of): | | | | 23dv. Due to (or as a consequence of): | | | | | | |
| 23dv. Due to (or as a consequence of): | | | | 23dw. Due to (or as a consequence of): | | | | | | |
| 23dw. Due to (or as a consequence of): | | | | 23dx. Due to (or as a consequence of): | | | | | | |
| 23dx. Due to (or as a consequence of): | | | | 23dy. Due to (or as a consequence of): | | | | | | |
| 23dy. Due to (or as a consequence of): | | | | 23dz. Due to (or as a consequence of): | | | | | | |
| 23dz. Due to (or as a consequence of): | | | | 23ea. Due to (or as a consequence of): | | | | | | |
| 23ea. Due to (or as a consequence of): | | | | 23eb. Due to (or as a consequence of): | | | | | | |
| 23eb. Due to (or as a consequence of): | | | | 23ec. Due to (or as a consequence of): | | | | | | |
| 23ec. Due to (or as a consequence of): | | | | 23ed. Due to (or as a consequence of): | | | | | | |
| 23ed. Due to (or as a consequence of): | | | | 23ee. Due to (or as a consequence of): | | | | | | |
| 23ee. Due to (or as a consequence of): | | | | 23ef. Due to (or as a consequence of): | | | | | | |
| 23ef. Due to (or as a consequence of): | | | | 23ef. Due to (or as a consequence of): | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

VS

CC 1000000 4 001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24256

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Francis Trusty | | | | 2. Date of Death Month Day Year July 28, 1999 | | 3. Time of Death 9:14 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Inside Medic 16 in parking lot at Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-07-0579 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) 10-06-21 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1825 N. Caroline Street | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade | | College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Water Dept | | 16b. Kind of Business/Industry City of Baltimore | |
| | 17. Father's Name (First, Middle, Last) Joseph M. Trusty | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sarah Boulden | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Jacqueline Trusty | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1825 N. Caroline Street Baltimore, Md. 21202 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery | | 20c. Date 08-04-99 | | 20d. Location - City or Town, State Baltimore, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>S. Valencia Holland</i> | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hemoptysis Associated with Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease Arteriosclerotic Cardiovascular Disease | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier <i>Theodore King</i> | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) July 29, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature <i>James B. Sparks</i> | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24257**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|---------------------------------|---|--|---------------------------------|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Bertha A. Thomas | | | | 2. Date of Death Month July Day 29 Year 1999 | | | | 3. Time of Death 8:35 PM | |
| | 4a. Facility Name (If not institution, give street and number) Stella Maris Hospice @ Mercy | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 219-32-9896 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) 01-22-37 | | 9. Birthplace (State or Foreign Country) SC | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits X Yes 2 No | | |
| 10e. Street and Number 501 E. Preston Street Apt. #105 | | | | 10f. Zip Code 21202 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) 8th Grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed | | | | 16b. Kind of Business/Industry in & out of home | | |
| 17. Father's Name (First, Middle, Last) Frank Code | | | | 18. Mother's Name (First, Middle, Maiden Surname) Inez Rice | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Darnett McDaniel | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3206 Lake Avenue Baltimore, Maryland 21213 | | | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery | | Date 08-04-99 | | 20c. Location - City or Town, State Lansdowne, MD | | |
| 21. Signature of Funeral Service Licensee <i>D. Valencia Holla</i> | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Liver Failure Due to (or as a consequence of): Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease Liver Masses, probable metastatic disease | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) STELLA MARIS AT MERCY HOSPICE | | | | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | |
| | | | | 28d. Describe how injury occurred | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>D. Valencia Holla</i> | | | | 29c. License number D 40854 | | | | 29d. Date signed (Month, Day, Year) July 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG, 301 ST PAUL PI BALTIMORE, MD 21202 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ATD

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24258

AMEND ITEMS: #24A, 31 PER VERBAL RESPONSE G774 8-3-99WR

Reg. No.

Certificate of Death

| | | | | | | | | |
|---|---|--|---------------------------------|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN TAYLOR | | | | 2. Date of Death Month Day Year 07 02 99 | | 3. Time of Death 7 pm | |
| | 4a. Facility Name (If not institution, give street and number) Frankford Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 217-26-9360 | | 6. Sex 10 M 20 F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) April 15, 1931 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10. Usual Residence of Decedent | | 11. Marital Status 1 X Navar Married 20 Married 30 Widowed 40 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No | |
| 10a. State Maryland | | 10b. County | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 10 Yes 20 No | | |
| 10e. Street and Number 5009 Frankford Avenue | | | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? U.S.A. | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | 16b. Kind of Business/Industry unknown | | 14. Race - American Indian, Black, White, etc. black | | |
| 17. Father's Name (First, Middle, Last) unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) unknown | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown | | | | |
| 20a. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place) in state | | 20c. Location - City or Town, State | | 20d. Date | | |
| 21. Signature of Funeral Service Licensee Joseph B. Van Sane | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebrovascular Accident | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 10 Yes 20 No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No | | | | | | | | |
| 25. Was case referred to medical examiner? 10 Yes 20 No | | 26. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 80 Other (Specify) | | | | | | |
| 27. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 10 Yes 20 No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier [Signature] | | 29c. License number D43725 | | 29d. Date signed (Month, Day, Year) 7/21/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHAMUD 201-109 Back River Neck Rd Baltimore MD 21221 | | | | | | | | |
| 31. Date filed (Month, Day, Year) 7/21/99 | | 32. Registrar's Signature [Signature] | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24259

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Valaida J. Taylor

2. Date of Death

Month Day Year
JULY 31st 1999

3. Time of Death

1:40 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

215-28-0952

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 12, 1933

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4008 Frankford Ave.

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Foster C. Smith, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Norris

19a. Informant's Name/Relationship (Type, Print)

Clyde P. Taylor - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4008 Frankford Ave. Balto. Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans 8-6-99 Owings Mills Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Plym B. Harris

22. Name and Address of Facility

March Funeral Home West, Inc.
4300 Wabash Ave. Balto. Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b.

VOLUME OVERLOAD

Due to (or as a consequence of):

c.

END STAGE RENAL DISEASE

Due to (or as a consequence of):

d.

DIABETES MELLITUS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Plym B. Harris RESIDENT, MD.

29c. License number

P-12560

29d. Date signed (Month, Day, Year)

JULY 31st 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANU GABA, RESIDENT, DEPT. OF MEDICINE, GOOD SAMARITAN HOSPITAL BALTIMORE.

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

Plym B. Harris

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VALAIDA TAYLOR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24260

| | | | | | | | | | | |
|---|--|--|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Constantine Tahinos | | | | | | 2. Date of Death Month Day Year JULY 29 1999 | | 3. Time of Death 3:30 A | |
| | 4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 152-16-3742 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 14, 1925 | | 9. Birthplace (State or Foreign Country) Patterson, N.J. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 6740 Brentwood Ave. | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Restaurant Mgr. | | | | 16b. Kind of Business/Industry Food | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Peter Tahinos | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anastasia Plakiotis | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Stephanie Tahinos/Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6740 Brentwood Ave., Balto., Md. 21222 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OakLawn Cemetery | | 20c. Date 8-2-99 | | 20d. Location - City or Town, State Balto., Md. | | | |
| | 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier  | | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 29, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STAN LOCKE MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature  | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24261

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY

VINCENT

VALENCIA

2. Date of Death
Month Day Year

JULY

31

1999

3. Time of Death
10:00 PM

4a. Facility Name (If not institution, give street and number)

BERLIN NURSING & REHABILITATION

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

214-16-6362

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC. 17, 1912

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WORCESTER

10c. City, Town or Location

OCEAN CITY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 PHILADELPHIA AVENUE

10f. Zip Code

21842

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No 1943-
If Yes, Give
Year or Dates: 194613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

AGENT

16b. Kind of Business/Industry

INSURANCE

17. Father's Name (First, Middle, Last)

ANDREW

VALENCIA

18. Mother's Name (First, Middle, Maiden Surname)

THERESA

BATTAGLIA

19a. Informant's Name/Relationship (Type, Print)

MRS. MARY VALENCIA (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 PHILADELPHIA AVENUE, OCEAN, MD. 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MARYLAND VETERANS CEMETERY

Date

8/4/99

20c. Location - City or Town, State

CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A.,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute + Chronic CHF

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Arteriosclerosis

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebro Vascular Accidents -

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEDERICO G. ARTHES, M.D. 46 TEAL CIRCLE BERLIN MD 21811 410-641-4400

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

HARRY VALENCIA

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
card.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

AUG 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24262

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Warren Vesta

2. Date of Death

Month Day Year
07 28 99

3. Time of Death

4:31 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Balt. city

4c. County of Death

Balt. city

5. Social Security Number

263-38-2871

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11-4-1931

9. Birthplace (State or Foreign Country)

FI

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1935 E. Belvedere Avenue

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

Collage (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Carr Lowery
Glass Company

17. Father's Name (First, Middle, Last)

Warren W. Vesta

18. Mother's Name (First, Middle, Maiden Summa)

Fannie Starks

19a. Informant's Name/Relationship (Type, Print)

Mary Vesta - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1935 E. Belvedere Balt, Md 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Memorial Park

Date

8-4-99

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

Gabrielle Clark

22. Name and Address of Facility

March West F.H.

4300 unbach Avenue Balt, Md

21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Cardiac Arrest

Due to (or as a consequence of):

ASCVD

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gabrielle Clark

29c. License number

D28266

29d. Date signed (Month, Day, Year)

8.3.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aye Win. MD. 5010 YORK RD, BALTO, MD 21212

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4386-510
JASON WHITE
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24263

| | | | | | | | | | | | | | | | |
|---|--|-------------------|---|--|--|--------------------------------------|---|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jason L. White | | | | 2. Date of Death Month Day Year JULY 25 1999 | | 3. Time of Death 2356 | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 3100 SWANN DRIVE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA | | | | | | | | |
| Funeral Director | 5. Social Security Number 217-94-0506 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 19 Yrs. | | 8. Date of Birth (Month, Day, Year) 03-07-80 | | 9. Birthplace (State or Foreign Country) MD | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number 1347 Walker Avenue | | | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? USA | | | | | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (14 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Paint Mixer | | | 16b. Kind of Business/Industry Sherwin Williams | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Robert J. White | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rochelle Shelton Spriggs | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Rochelle Shelton Spriggs | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1347 Walker Avenue Baltimore, MD. 21239 | | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery | | | 20c. Date 08-04-99 | | 20d. Location - City or Town, State Baltimore, MD | | | | | | | |
| 21. Signature of Funeral Service Licensee <i>S. Valencia Holland</i> | | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <i>Intracranial Shotgun Wound</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) <i>Found 7/25/99</i> | | 28b. Time of Injury <i>2340 M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred <i>Subject shot self</i> | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>park bench</i> | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>3100 block Swann Drive Baltimore Maryland</i> | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier <i>Theodore M. King</i> | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) JULY 26, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE M. KING</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AT 16

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24264

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Mary G. Wingate

2. Date of Death

July 28 1999

3. Time of Death

0005

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

N/A

4c. County of Death

Baltimore

5. Social Security Number

248-60-4530

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 24 1915

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

619 Joppa Farm Rd.

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Waterman Grayes

18. Mother's Name (First, Middle, Maiden Surname)

Viola Moody

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary Coleman (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

619 Joppa Farm Rd. Joppa Md. 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Effingham Bpt. Ch. Cem.

Date

8/7/99

20c. Location - City or Town, State

South Carolina

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebral Vascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Sepsis, poss. Uro sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph L. Russ MD

29c. License number

D35889

29d. Date signed (Month, Day, Year)

30 July 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALFRED SPANIS 615 W. MACPHAIL BELAIR MD 21014

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

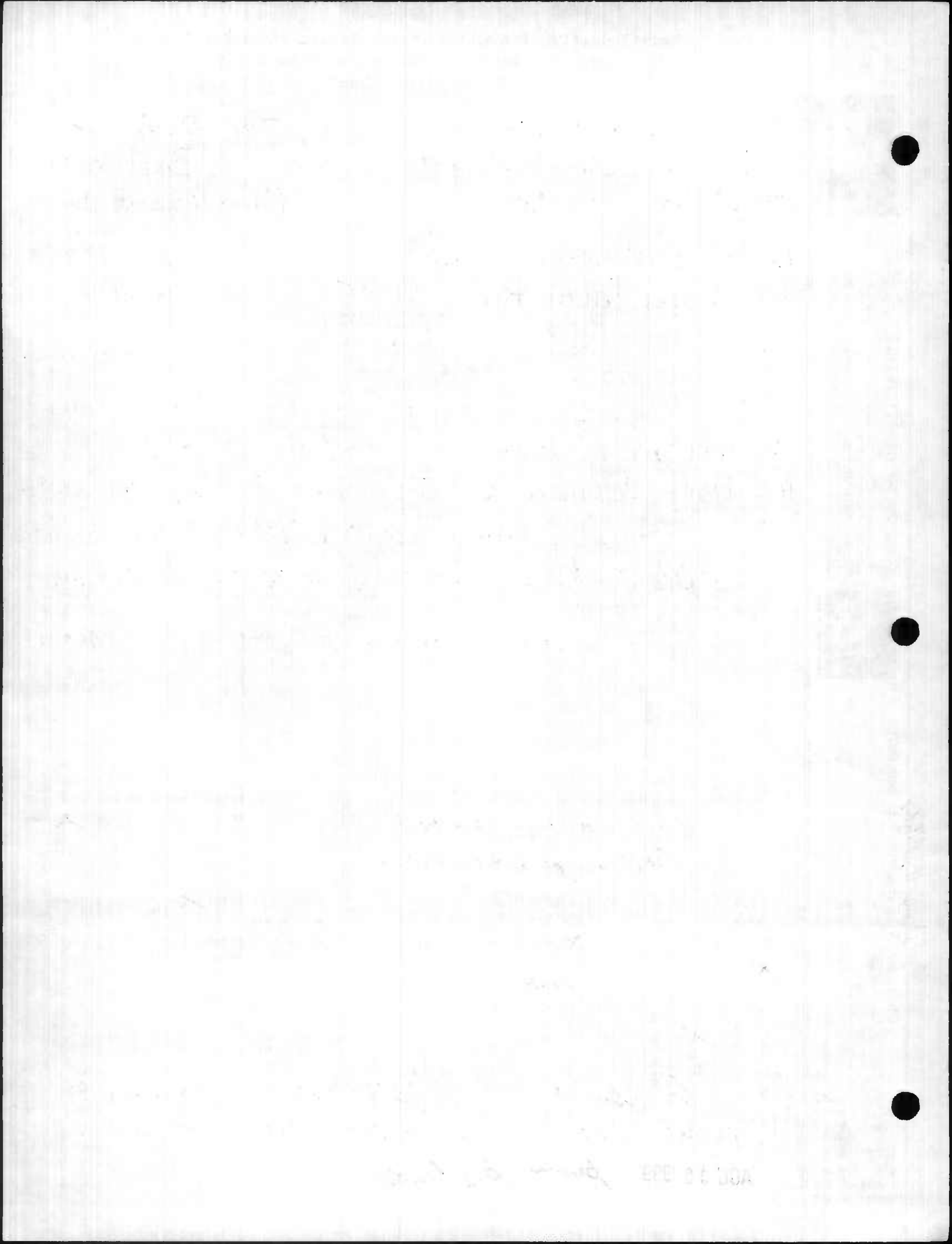
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24265

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|--|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mildred M. Wills | | | | 2. Date of Death Month Day Year August 2, 1999 | | 3. Time of Death 10:00 a.m. | | |
| | 4a. Facility Name (If not institution, give street and number) 4212 Woodlea Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 218-36-2299 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 18, 1940 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 4212 Woodlea Avenue | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Representative | | 16b. Kind of Business/Industry Insurance | | | | | |
| 17. Father's Name (First, Middle, Last) Harvey J. Wills | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dora K. Morgal | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ms. Nancy E. Smith (Cousin) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2618 Hillcrest Avenue Baltimore, MD 21234 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | Date 8/5/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee Michael E. Canapp | | 22. Name and Address of Facility LEONARD J. RUCK, INC. | | 5305 Harford Road Baltimore, MD 21214 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. essential hypertension Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cigarette smoking - 2 packs daily. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of certifier Frank S. Palmisano, Jr. MD | | 29c. License number DO9475 | | 29d. Date signed (Month, Day, Year) 8-3-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANK S. PALMISANO, JR. MD 5122 HARFORD RD. BALTIMORE, MD. 21214. | | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature Kevin B. Sparks | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24266

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY JEAN WOOD

2. Date of Death

JULY 29 1999

3. Time of Death

3:48 PM

4a. Facility Name (If not institution, give street and number)

3268 ELMMEDE ROAD

4b. City, Town, or Location of Death

ELLCOTT CITY

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

240-60-9617

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 3, 1942

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HOWARD

10c. City, Town or Location

ELLCOTT CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3268 ELMMEDE ROAD

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

BACHELOR DEGREE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DIRECTOR

16b. Kind of Business/Industry

DAY CARE NURSERY

17. Father's Name (First, Middle, Last)

JAMES

18. Mother's Name (First, Middle, Maiden Surname)

BETTY

BOND

19a. Informant's Name/Relationship (Type, Print)

RODDIE WOOD (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3268 ELMMEDE RD., ELLCOTT CITY, MD. 21043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUIDRIDGE CEMETERY 8-2-99 BALTIMORE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Ischemia

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45708

29d. Date signed (Month, Day, Year)

July 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary J. Kerkner MD 2435 W BELVEDERE BALTO MD 21225

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24267

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Ernestine Eldrema Woods</u> | | | | 2. Date of Death Month <u>JULY</u> Day <u>30</u> Year <u>1999</u> | | 3. Time of Death <u>1043 AM</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>SINAI HOSPITAL</u> | | | | 4b. City, Town, or Location of Death <u>BALTIMORE</u> | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number <u>231-30-5322</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>71</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <u>9-15-1927</u> | 9. Birthplace (State or Foreign Country) <u>La</u> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <u>MD</u> | | 10b. County <u>NA</u> | | 10c. City, Town or Location <u>Baltimore</u> | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number <u>4305 Umatilla Avenue</u> | | | | 10f. Zip Code <u>21215</u> | | 10g. Citizen of What Country? <u>U.S.A</u> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th grade</u> College (1-4or 5+) <u>NA</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Nurse</u> | | | 16b. Kind of Business/Industry <u>Hospital - Nursing Home</u> | |
| 17. Father's Name (First, Middle, Last) <u>Eddie Taylor</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Peart Wood</u> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Deborah Lee Pitts - Niece</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>21133 3924 Zurich Road Randallstown, MD</u> | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u> | | Date <u>8-4-99</u> | | 20c. Location - City or Town, State <u>Balto Co. MD</u> | | |
| 21. Signature of Funeral Service Licensee <u>Wladyslaw W...</u> | | | | 22. Name and Address of Facility <u>Harold H. West 21215 Wabash Avenue Balto, MD</u> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) <u>a. HEMORRHAGIC CEREBROVASCULAR ACCIDENT</u> | | | | | | | | <u><36 HOURS</u> |
| Due to (or as a consequence of): <u>b. HYPERTENSION</u> | | | | | | | | <u>>20 YEARS</u> |
| Due to (or as a consequence of): <u>c.</u> | | | | | | | | |
| Due to (or as a consequence of): <u>d.</u> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>1) DIABETES MELLITUS TYPE II 2) CONGESTIVE HEART FAILURE 3) GRAVE'S DISEASE 4) ATRIAL FIBRILLATION 5) END STAGE RENAL DISEASE 6) CORONARY ARTERY DISEASE</u> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>Dr. [Signature] MEDICAL RESIDENT</u> | | | 29c. License number <u>D0052122</u> | | 29d. Date signed (Month, Day, Year) <u>JULY 30 1999</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>PETA-GAY JACKSON BOOTH 2401 W. BELVEDERE AVE, BALTIMORE, MD 21215</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 03 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

WOODS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

ERNESTINE

Division of Vital Records, P.O. Box 68760, R

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24268

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CATHERINE E WILSON | | | | 2. Date of Death Month Day Year JULY 29 1999 | | 3. Time of Death 12:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) Howard County General | | | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 212-36-0696 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 61 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-4-1937 | |
| | 9. Birthplace (State or Foreign Country) Md | | 10a. State Md | | 10b. County Howard | | 10c. City, Town or Location Columbia | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 5255 Rivendell Lane | | 10f. Zip Code 21044 | | 10g. Citizen of What Country? U.S.A | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher Aide | | 16b. Kind of Business/Industry School | | 17. Father's Name (First, Middle, Last) Moses Owens | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Beatrice | | 19a. Informant's Name/Relationship (Type, Print) Walters B. Wilson - Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5255 Rivendell Lane Columbia, Md 21044 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem Park | | 20c. Location - City or Town, State Randallstown, Md | | 21. Signature of Funeral Service Licensee Gabrielle Cook | | 22. Name and Address of Facility March F. A. West 21215 4300 unakash Avenue Balto, Md | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. POSSIBLE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 6 HOURS | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. POST-OPERATIVE STATUS - MULTIPLE BOWEL RESECTIONS AND REPAIR OF ABDOMINAL WOUND | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| State Registrar | 29b. Signature and title of certifier Rene L. Gilbert | | 29c. License number D 17502 | | 29d. Date signed (Month, Day, Year) JULY 29, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RENE L GILBERT 14201 LAUREL PARK DR LAUREL MD 20707 | |
| | 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature B. Spauld | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24269

Certificate of Death

Reg. No.

AMEND #7 PER F.H. G774 8-3-99 J.A.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY D WIATROWSKI

2. Date of Death

JULY 30 1999 Year

3. Time of Death

7:15 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice-Mercy Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

5. Social Security Number

218-44-9931

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 30 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1613 Doolittle Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Edward I Wiatrowski

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Elizabeth Combs

19a. Informant's Name/Relationship (Type, Print)

James Eugene Bolt/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1613 Doolittle Road Baltimore Md. 21221

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc

Date

8/2/99

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connolly

22. Name and Address of Facility

Connolly Funeral Home of Essex

300 Mace Ave. Baltimore Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Metastatic Breast Cancer to Bones

Due to (or as a consequence of):

Approximate interval Between Onset and Death

3 YEARS

Immediate Cause (Final disease or condition resulting in death)

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Paul Anthony

29c. License number

D40854

29d. Date signed (Month, Day, Year)

July 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG 301 ST PAUL PI, BALTIMORE, MD 21202

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Wiatrowski, Mary

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text throughout the page, likely bleed-through from the reverse side. Some fragments are visible:]

[Faint text at top left]

[Faint text at top center]

[Faint text at top right]

[Faint text in middle left]

[Faint text in middle right]

[Faint text at bottom left]

[Faint text at bottom center]

[Faint text at bottom right]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24270

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helene C. Wajer

2. Date of Death

August 1, 1999

3. Time of Death

5:50 AM

4a. Facility Name (If not institution, give street and number)

1205 Hanson Road

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

212-01-4314

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 6, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

1205 Hanson Road

10f. Zip Code

21040

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Adam Jasinski

18. Mother's Name (First, Middle, Maiden Surname)

Marie Radomski

19a. Informant's Name/Relationship (Type, Print)

Nancy C. Daniecki (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3603 MyLadys View Court, Monkton, Maryland 21111

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Rosary Cemetery

Date

8/4/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Mark T. Zup...

22. Name and Address of Facility

Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis

Due to (or as a consequence of):

Decubitus ulcers of hip

b.

Due to (or as a consequence of):

Alzheimer's Disease

c.

Due to (or as a consequence of):

Constipation chronic

d.

Approximate Interval Between Onset and Death

3 days

2 weeks

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary incontinence

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

BOARDING HOME

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

PERFECTO, Valarao

29c. License number

D16389

29d. Date signed (Month, Day, Year)

August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERFECTO, C. VALARAO, M.D. 1716 HARTFORD RD FALLSTON MD 21047

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

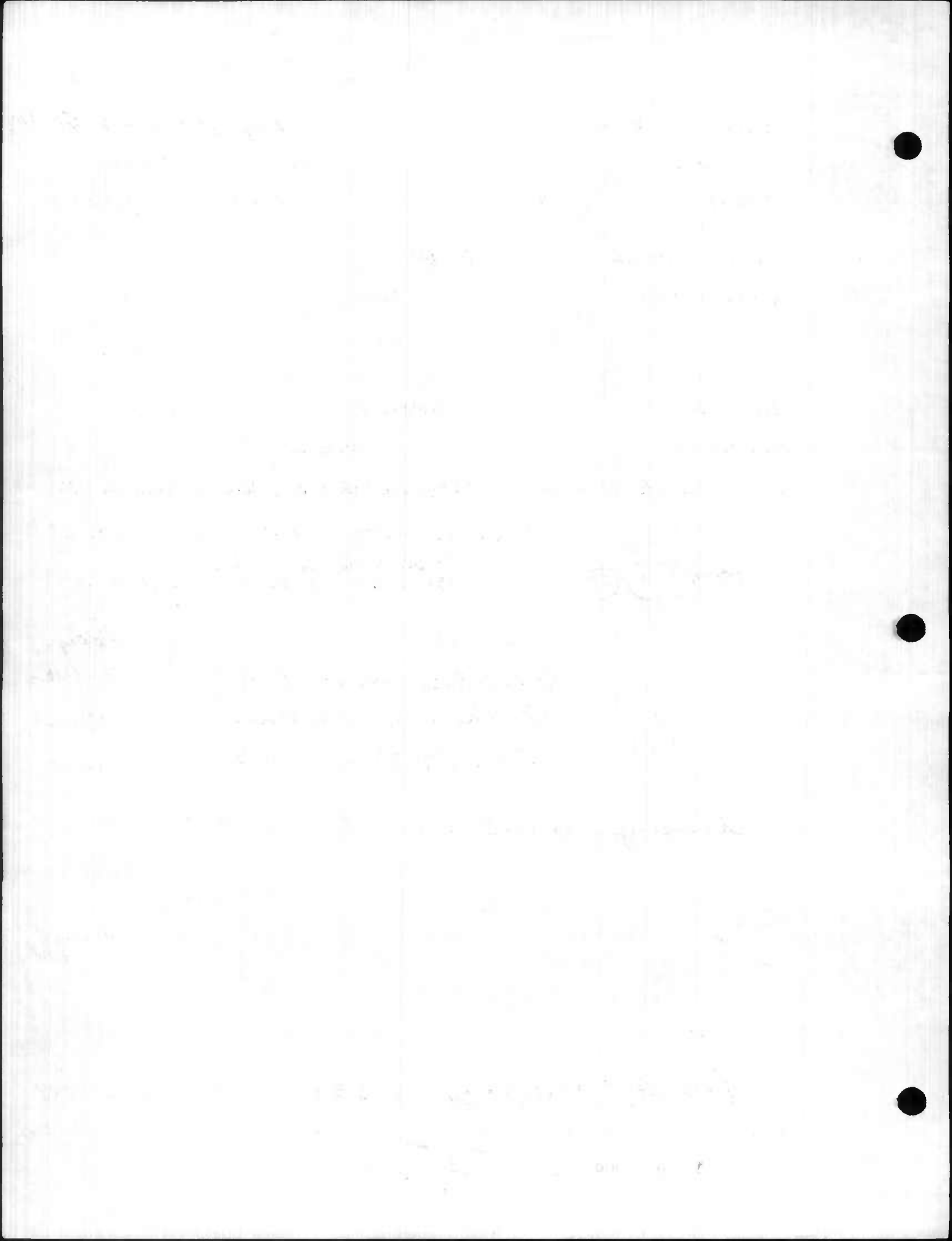
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24271

| | | | | | | |
|---|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen Young | | 2. Date of Death July 31, 1999 | | 3. Time of Death 11:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) Levindale Nursing Center | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 213 14 8709 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 22, 1921 |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| Usual Residence of Decedent | | | | | | |
| 10a. State Maryland | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 600 Light St. | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) (Unknown) College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Counter Clerk | | 16b. Kind of Business/Industry Bakery | |
| 17. Father's Name (First, Middle, Last) (Unknown) | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna (Unknown) | | | |
| 19a. Informant's Name/Relationship (Type, Print) Walter Young / Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29537 Golton Dr., Easton, MD 21601 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | 20c. Date 8/4/99 | | 20d. Location - City or Town, State Baltimore, MD |
| 21. Signature of Funeral Service Incinerator <i>Stephen D. Lohrmann</i> | | | 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Respiratory Failure Due to (or as a consequence of): b. Recurrent Aspiration Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death months months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus, CHF, HBP, Cerebrovascular disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>James M. Lutz</i> | | 29c. License number 033943 | | |
| 29d. Date signed (Month, Day, Year) 7/31/99 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isabel N. Levy Levindale | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature <i>James B. Sparks</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

10/10/1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24272

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Greta Veronica Ashley

2. Date of Death

Month
07Day
17Year
1999

3. Time of Death

12:31 pm

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

NA

6. Sex

☐ M☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan 13, 1936

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

WI

10b. County

Jamaica

10c. City, Town or Location

Clarendon

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

9 Williams Avenue

10f. Zip Code

NA

10g. Citizen of What Country?

Jamaica

11. Marital Status

☐ Never Married☐ Married☒ Widowed☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (13-16)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Rupert Henry - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5504 63rd Avenue, Riverdale, MD 20737

20a. Method of Disposition

☐ Burial☐ Cremation☒ Removal from State☐ Donation☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

unk

Date

7/24/99

20c. Location - City or Town, State

Jamaica, WI

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.
600 Kennedy Street, N.W., Wash., DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary emboli
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypotension

Seizure disorder

Renal insufficiency

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D30318

29d. Date signed (Month, Day, Year)

7/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Catevenis, M.D., 3001 Hospital Drive Cheverly, MD 20785

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1



MILTON BURLEY
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G774 8-4-99 WR. **Certificate of Death**

Reg. No.

99 224273

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILTON BURLEY SR.

2. Date of Death

JULY 18 1999

3. Time of Death

12:21 A

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

577-80-0500

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 27, 1957

9. Birthplace (State or Foreign Country)

Cheverly, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2002 Ravenwood Street

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mail Supervisor

16b. Kind of Business/Industry

Postal

17. Father's Name (First, Middle, Last)

George Burley

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Butler

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Burley - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2002 Ravenwood St., Hyattsville, MD 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection CH. Cemetery 7/22/99 Clinton, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Henry K. Robbins

22. Name and Address of Facility

R.N. Horton Co. Morticians, Inc.
600 Kennedy St., N.W. Washington, DC 20011

23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis J. Chup

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chup

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

Beverly B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24274

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SIDNEY J. ARMORE

2. Date of Death
Month Day Year
JULY 17, 19993. Time of Death
9:08 AM

4a. Facility Name (If not Institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

130-12-6189

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPTEMBER 6, 1914

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6111 MONTROSE ROAD #726

10f. Zip Code

20852

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

STATISTICIAN

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

BENJAMIN AREMOWITZ

18. Mother's Name (First, Middle, Maiden Surname)

SARAH JACOBS

19a. Informant's Name/Relationship (Type, Print)

CAROL ANN SHERMAN (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9709 HOLLOWAY HILL COURT POTOMAC MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

KING DAVID MEMORIAL GARDENS 7/19/99 FALLS CHURCH VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL
CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE MD
2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. cardiac arrest

Due to (or as a consequence of):

b. arteriosclerotic heart disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 minutes

8 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

gastrointestinal bleeding
duodenal ulcer
diabetes mellitus, type I

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D09946

29d. Date signed (Month, Day, Year)

7/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1801 East Jefferson St.

Rockville MD 20852

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

Denise G. Sparks

State
RegistrarBaltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24275

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|-----------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Niels Peter Andersen | | | | 2. Date of Death Month Day Year July 17, 1999 | | | | 3. Time of Death 1:00pm | |
| | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 097-07-4016 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 96 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) Feb. 19, 1903 | | 9. Birthplace (State or Foreign Country) Michigan | | 10a. State Md. | | 10b. County Montgomery | | 10c. City, Town or Location Montgomery Village | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 19441 Brassie Place #102 | | | | 10f. Zip Code 20886 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automobile Dealer | | | | 16b. Kind of Business/Industry Auto Sales | |
| | 17. Father's Name (First, Middle, Last) Niels P. Andersen | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mathilda Knudsen | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Lorraine Pentlicki (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #7 Redding Ridge Dr. Gaithersburg, Md. 20878 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Intombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Data July 21, 1999 | | 20c. Location - City or Town, State Silver Spring, Md. | | | |
| | 21. Signature of Funeral Service Licensee Curtis E. Day | | | | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RENAL FAILURE Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d. AND AORTIC STENOSIS (SEVERE) | | | | | | | | Approximate Interval Between Onset and Death 1 MONTH YEARS YEARS YEARS | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTRO INTESTINAL BLEEDING AND OBTUNDED MENTAL STATE. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Samir Ngima, MD. | | 29c. License number D18551 | | 29d. Date signed (Month, Day, Year) JULY, 18, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMIR NGIMA, MD. 7610 CARROLL AV., TAKOMA PARK, MD, 20912 | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 20 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24276

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LONNIE W. ALLEN

2. Date of Death

Month Day Year
JULY 19 1999

3. Time of Death

2052

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

215-50-8956

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

48

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
NOV. 5 1950

9. Birthplace (State or Foreign Country)

D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3522 ROCKWAY AVENUE

10f. Zip Code

21403

10g. Citizen of What Country?

US

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

4 yrs.

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)HOUSING REHABILITATION
OFFICER

16b. Kind of Business/Industry

MD. DEPARTMENT OF
HOUSING & COMMUNITY
DEVELOPMENT

17. Father's Name (First, Middle, Last)

ARIS T. ALLEN

18. Mother's Name (First, Middle, Maiden Surname)

FAYE WATSON

19a. Informant's Name/Relationship (Type, Print)

VALERIE V. ALLEN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3522 ROCKWAY AVE. ANNAPOLIS, MD. 21403

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS 7/26/99 ANNAPOLIS, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Harry R. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Sepsis
Due to (or as a consequence of):Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. ARDS, multi-system organ failure
Due to (or as a consequence of):c. perforated duodenal ulcer.
Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

11 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Terri Lynn M. Juttner

29c. License number

D38829

29d. Date signed (Month, Day, Year)

7/20/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Terri Lynn Juttner MD 600 Ridgely Ave #222 ANNAPOLIS.

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24277

| | | | | | | | | | | | |
|--|---|---|--|---|---|--------------------------|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Florine R. Brice | | | | 2. Date of Death Month Day Year July 17, 1999 | | | | 3. Time of Death 11:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 577-60-5504 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) July 21, 1915 | | 9. Birthplace (State or Foreign Country) Washington, D.C. | | |
| | Usual Residence of Decedent | | | | 10a. State N/A | | | | 10b. County N/A | | 10c. City, Town or Location Washington, D.C. |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 322 Missouri Avenue N.W. | | | | 10f. Zip Code 20011 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant | | | | 16b. Kind of Business/Industry U.S. Government | | | |
| 17. Father's Name (First, Middle, Last) Howard Brice | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cora Curtis | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) William Davis, brother-in-law | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5209 - 2nd Street N.W., Washington, D.C. 20011 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Natl. Mem. Park | | | | 20c. Location - City or Town, State Laurel, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Rectal Cancer</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last { | | | | | | | | | | Approximate Interval Between Onset and Death 1 week 1 year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D21900 | | 29d. Date signed (Month, Day, Year) July 18, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith S. Ho 7610 Carroll Ave. #280 Takoma Park, Md. 20912 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24278

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rita Bisacquino | | | | 2. Date of Death Month Day Year July 14, 1999 | | 3. Time of Death 10:10 AM | |
| | 4a. Facility Name (If not institution, give street and number) Spa Creek Nursing Facility | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 053-18-7253 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) May 20, 1923 | |
| | 9. Birthplace (State or Foreign Country) Bronx, NY | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 35 Milkshake Lane | | 10f. Zip Code 21403 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Legal Secretary | | 16b. Kind of Business/Industry Law Office | | | |
| | 17. Father's Name (First, Middle, Last) Thomas Mammarella | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elena Farfone | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Thomas Bisacquino - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12020 Rose Hall Drive Clifton, Virginia 20124 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Location - City or Town, State 7/17/99 Mt. Pleasant, NY | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Capitol Funeral Service, Inc. 7211 Lee Highway Falls Church, Virginia 22046 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Uremia</u> Due to (or as a consequence of): b. <u>END STAGE Kidney disease</u> Due to (or as a consequence of): c. <u>Hypertension</u> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5 days 4 years 30 years | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Aortic stenosis</u> <u>peripheral vascular disease</u> <u>Coronary atherosclerotic heart disease</u> | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number N08314 | | 29d. Date signed (Month, Day, Year) 7/14/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George C. Samaras MD 205 Ridgely Ave. Annapolis, MD 21401 | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24279

EDWARD BARTLETT

| | | | | | | | | |
|---|---|--|---|---|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward Bruce Bartlett | | | | 2. Date of Death Month Day Year JULY 16, 1999 | | 3. Time of Death 0230 AM | |
| | 4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 634-18-9098 | 6. Sex 15 M 2 F | 7. Age (In yrs. last birthday) 51 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 17, 1947 | | 9. Birthplace (State or Foreign Country) Buffalo, NY |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Kensington | | | 10d. Inside City Limits 1 X Yes 2 No | |
| 10e. Street and Number 11311 Woodson Avenue | | | | 10f. Zip Code 20895 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: Vietnam | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner / Operator | | | 16b. Kind of Business/Industry Computer Software | |
| 17. Father's Name (First, Middle, Last) Burdette Bartlett | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence May Harbeck | | | | |
| 19a. Informant's Name/Relationship (Type, Print) (Sister) Gail M. Bartlett - Murray | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8943 W. Manzanita Dr. Peoria, AZ 85345 | | | | |
| 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 7/19/99 | | 20c. Location - City or Town, State Alexandria, Virginia | | |
| 21. Signature of Funeral Service Licensee <i>Sharon W. Love</i> | | | | 22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown |
| 24a. Was an autopsy performed? 1 X Yes 2 No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 No |
| 25. Was case referred to medical examiner? 1 X Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | |
| 27. Manner of Death 1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7/15/99 | | 28b. Time of Injury 1215 M | | 28c. Injury at Work? 1 Yes 2 X No | | 28d. Describe how injury occurred Pedestrian Struck by Motor Vehicle |
| 29a. Certifier (Check only one) 1 X Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated. | | 29b. Signature and title of certifier <i>J. Pestaner, MD</i> | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | 32. Registrar's Signature <i>Sharon G. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24280

| | | | | | | | | |
|--|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MATTIE BEASLEY | | | | 2. Date of Death Month Day Year JULY 18 1999 | | 3. Time of Death 5:58 pm | |
| | 4a. Facility Name (If not Institution, give street and number) 831 BESTGATE ROAD | | | | 4b. City, Town, or Location of Death ANNAPOLIS | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 273-24-8634 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 20 1916 | 9. Birthplace (State or Foreign Country) KENTUCKY |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location ANNAPOLIS | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 831 BESTGATE ROAD | | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? US | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Collage (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPING | | | 16b. Kind of Business/Industry UNIVERSITY OF CINCINNATI | |
| 17. Father's Name (First, Middle, Last) JOHN BEASLEY | | | | 18. Mother's Name (First, Middle, Maiden Surname) LIZZIE BLYTH | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MAURIE NE NOLAND (COUSIN) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2417 WEAVER ST. DAYTON, OHIO 45408 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS | | 20c. Location - City or Town, State 7/23/99 ANNAPOLIS, MD. | | |
| 21. Signature of Funeral Service Licensee Harry D. Reese | | | | 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { Respiratory Failure Due to (or as a consequence of) Plural Effusion Due to (or as a consequence of) Lung Metastasis Due to (or as a consequence of) Bladder Cancer | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Curtis Harris M.D. | | 29c. License number D0053306 | | 29d. Date signed (Month, Day, Year) 7/21/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Curtis Harris 600 Ridgely Ave Suite 231 Annapolis, MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | | | 32. Registrar's Signature Denise B. Sparks | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24281

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TIMOTHY

2. Date of Death

JULY 13 1999

3. Time of Death

8:10 AM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NONE

Funeral
Director

5. Social Security Number

216-17-9980

6. Sex

15 M 20 F

7. Age (In yrs. last birthday)

12

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 24 1987

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 X Yes 20 No

10e. Street and Number

12 C BENS DRIVE

10f. Zip Code

21403

10g. Citizen of What Country?

US

11. Marital Status

1 X Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

STUDENT

16b. Kind of Business/Industry

ANNAPOLIS MIDDLE SCHOOL

17. Father's Name (First, Middle, Last)

KENNETH BRASHEARS SR.

18. Mother's Name (First, Middle, Maiden Surname)

DARLENE HARROD

19a. Informant's Name/Relationship (Type, Print)

DARLENE BRASHEARS (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 C BENS DRIVE ANNAPOLIS, MD. 21403

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS 7/19/99 ANNAPOLIS, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Larry S. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIORGAN FAILURE

Due to (or as a consequence of):

b. HYPERKALEMIA

Due to (or as a consequence of):

c. HERPES PNEUMONITIS

Due to (or as a consequence of):

d. ENCEPHALOPATHY

Approximate Interval Between Onset and Death

4 days

1 day

12 days

8 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LIVER FAILURE, RENAL FAILURE

STATUS POST BONE MARROW TRANS-

PLANT, Hemorrhagic CYSTITIS

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation
20 Accident 60 Could not be determined
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anne Marie Querguerian

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JULY 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNE MARIE QUERGUERIAN JOHNS HOPKINS HOSPITAL

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

B. Spade

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Handwritten signature

1000 000 000

99 24282

Baltimore, Maryland 21215-0020

10 JUL 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24283

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Eugene W Boardley</i> | | | | 2. Date of Death Month <i>7</i> Day <i>10</i> Year <i>1999</i> | | 3. Time of Death <i>08:25</i> | |
| | 4a. Facility Name (If not Institution, give street and number) <i>Anne Arundel Medical Center</i> | | | | 4b. City, Town, or Location of Death <i>Annapolis</i> | | 4c. County of Death <i>Anne Arundel</i> | |
| Funeral Director | 5. Social Security Number <i>217-07-5697</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>89</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>APRIL 20 1910 MARYLAND</i> | |
| | Usual Residence of Decedent 10a. State <i>MARYLAND</i> 10b. County <i>ANNE ARUNDEL</i> 10c. City, Town or Location <i>CHURCHTON</i> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number <i>5605 BOARDLEY DRIVE</i> | | | | 10f. Zip Code <i>20733</i> | | 10g. Citizen of What Country? <i>US</i> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i> College (1-4 or 5+) <i>0</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>CUSTODIAN</i> | | 16b. Kind of Business/Industry <i>PRINCE GEORGE CO. PUBLIC SCHOOLS</i> | | |
| 17. Father's Name (First, Middle, Last) <i>JOHN C. BOARDLEY</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>MATTIE ROBERTS</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>BERNICE BOARDLEY (WIFE)</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5605 BOARDLEY DR. CHURCHTON, MD. 20733</i> | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>BELLVILLE CEMETERY</i> | | Date <i>7/19/99</i> | | 20c. Location - City or Town, State <i>PORTSMOUTH, VA.</i> | |
| 21. Signature of Funeral Service Licensee <i>Larry H. Reese</i> | | | | | 22. Name and Address of Facility <i>WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Hyperosmolar coma</i> Due to (or as a consequence of): <i>hypernatremia</i> Due to (or as a consequence of): <i>dehydration</i> Due to (or as a consequence of): Approximate Interval Between Onset and Death <i>days</i> <i>days</i> <i>day</i> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute renal failure</i> <i>dementia</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier <i>Peter Stengel MD</i> | | 29c. License number <i>D0053277</i> | | 29d. Date signed (Month, Day, Year) <i>7/10/99</i> | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>64 Franklin St. Annapolis MD 21401 Peter Stengel MD</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>JUL 13 1999</i> | | | 32. Registrar's Signature <i>B. Smith</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Handwritten signature or initials at the bottom left of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-24284

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Mary Bizot

2. Date of Death
Month Day Year
July 18, 1999

3. Time of Death

3:10pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Bedford Court Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

575-20-1037

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Aug. 22, 1915

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7616 Carteret Road

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Junior High School Teacher

16b. Kind of Business/Industry

DC Public School

17. Father's Name (First, Middle, Last)

Franz Joseph Parduhn

18. Mother's Name (First, Middle, Maiden Surname)

Mary Agnes Stupp

19a. Informant's Name/Relationship (Type, Print)

Mary Frances Franklin/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7616 Carteret Road, Bethesda, MD 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven

Date

July 21

1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

E. S. Scurto

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd.W., Silver Spring, MD 20901

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cerebrovascular accident

10years

Due to (or as a consequence of):

b. Urosepsis

2weeks

Due to (or as a consequence of):

c. Rectal bleeding

1day

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Arthur Schoengold

29c. License number

D18726

29d. Date signed (Month, Day, Year)

July 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur Schoengold, MD 18111 Prince Philip Dr., Olney, MD 20832

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24285

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Fred Boxall

2. Date of Death

Month Day Year
July 20, 1999

3. Time of Death

12:17pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-26-1423

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 24, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

908 Laredo Road

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Gas Station

17. Father's Name (First, Middle, Last)

James Albert Boxall

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Mae Dillehay

19a. Informant's Name/Relationship (Type, Print)

Annie A. Boxall / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

908 Laredo Road, Silver Spring, MD 20901

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veteran's Cemetery

Date

July 26

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

James S. Dole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Carcinoma of Colon with metastasis

Approximate interval between Onset and Death

3 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Myron L. Lenkin M.D.

29c. License number

DD 6674

29d. Date signed (Month, Day, Year)

7/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYRON L. LENKIN MD

*2309 SHOREFIELD RD
WHEATON MD*

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

*Beverly B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24286

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE EDWARD BROWN, JR

2. Date of Death

Month
JULYDay
15Year
1999

3. Time of Death

6:45 PM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

567-05-6369

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MARCH 6, 1920

9. Birthplace (State or Foreign Country)

CALIFORNIA

Usual Residence of Decedent

10a. State

CA

10b. County

SAN BERNADINO

10c. City, Town or Location

SAN BERNADINO

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

873 BERNARD WAY

10f. Zip Code

92404

10g. Citizen of What Country?

U. S. A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 +

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CONGRESSMAN

16b. Kind of Business/Industry

U. S. HOUSE OF REPRESENTATIVES

17. Father's Name (First, Middle, Last)

GEORGE EDWARD BROWN

18. Mother's Name (First, Middle, Maiden Surname)

BIRD KILGORE

19a. Informant's Name/Relationship (Type, Print)

MARTA MACIAS BROWN - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

873 BERNARD WAY SAN BERNADINO, CA 92404

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NATIONAL CREMATORY

Date

7/22/99

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

Thomas E. Hornbaker

22. Name and Address of Facility

JOSEPH GAWLER'S SONS

5130 WI AVE. N.W. WASHINGTON, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ASYTOL

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

c. MULTI ORGAN SYSTEM FAILURE

Due to (or as a consequence of):

d. PROSTHETIC VALVE ENDOCARDITIS and RHEUMATIC VALVULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

0101-56879 (VA)

29d. Date signed (Month, Day, Year)

7/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. A. ELSTER, LT, MC, USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24287

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NATHAN BURNS | | | | 2. Date of Death Month Day Year JULY 18, 1999 | | 3. Time of Death 1:10 AM | |
| | 4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 579-10-1676 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 7, 1913 | |
| | 9. Birthplace (State or Foreign Country) RUSSIA | | 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location ROCKVILLE | |
| Usual Residence of Decedent | | 10d. inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 6121 MONTROSE ROAD | | 10f. Zip Code 20852 | | |
| 10g. Citizen of What Country? UNITED STATES | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WW II If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4+ College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANICAL ENGINEER | | 16b. Kind of Business/Industry PRIVATE OWNER | | |
| 17. Father's Name (First, Middle, Last) SCHMUEL MA NAKAM | | | | 18. Mother's Name (First, Middle, Maiden Surname) RAHEL GREENBERG | | | | |
| 19a. Informant's Name/Relationship (Type, Print) BERNICE MILLER (POWER OF ATTORNEY) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5225 POOKS HILL ROAD #304 N BETHESDA MD 20814 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ADAS ISRAEL CEMETERY | | Date 7/20/99 | | 20c. Location - City or Town, State WASHINGTON DC | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPEL 1170 ROCKVILLE PIKE ROCKVILLE MD 20852 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Pneumonia Due to (or as a consequence of): b. Arteriosclerosis cardiovascular disease Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 1 week Years Years | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier MD | | 29c. License number D23958 | | 29d. Date signed (Month, Day, Year) 7/18/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burt I. Feldman MD 6105 Montrose Rd., Rockville MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24288

Amend #26, 7/23/99, BMW, Montg. Co

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LOLRINE BURTON | | | | 2. Date of Death Month July Day 17 Year 1999 | | 3. Time of Death 9:15 pm | |
| | 4a. Facility Name (If not institution, give street and number) 13513 PARTRIDGE DRIVE | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 218-34-6268 | | 8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 13, 1916 | 9. Birthplace (State or Foreign Country) Star City, MI |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Burtonsville | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 15815 Oursler Road | | | | 10f. Zip Code 20866 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | 16b. Kind of Business/Industry Medical | | |
| 17. Father's Name (First, Middle, Last) Claire Eugene Miller | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eva Mae Curtis | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ruth Burton Digel/ Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15815 Oursler Road, Burtonsville, MD 20866 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Waugh Chapel Cemetery | | Date July 21 1999 | | 20c. Location - City or Town, State Glen Arm, MD | | |
| 21. Signature of Funeral Service Licensee J. Ken Skala | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W., Silver Spring, MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ANTHROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | Approximate Interval Between Onset and Death |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RHEUMATOID ARTHRITIS | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Caretaker's residence | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier ma (ONE) | | | | | | |
| 29c. License number 015236 | | 29d. Date signed (Month, Day, Year) July 17, 1999 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARIE MARGOLIS, MD, ONE/11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24289

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Keane Baldwin

2. Date of Death
Month Day Year
July 18, 19993. Time of Death
11:28 AM

4a. Facility Name (If not Institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-82-4217

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 4, 1964

9. Birthplace (State or Foreign

Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

5911 Ryland Drive

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Wood Worker

16b. Kind of Business/Industry

Wood Working

17. Father's Name (First, Middle, Last)

Thomas Baldwin

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Keane

19a. Informant's Name/Relationship (Type, Print)

Kevin J. Baldwin/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1010 Strout Street, Silver Spring, MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery Crematorium, Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

MO0689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue,

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Lung Carcinoma

Approximate Interval Between Onset and Death

8 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Victor M. Priego

29c. License number

023308

29d. Date signed (Month, Day, Year)

07/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTOR M. PRIEGO, MD 9707 MEDICAL CENTER DR. ROCKVILLE, MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

Beverly B. Sparks

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director


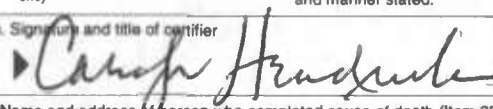
Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24290

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LUCINE ROSEMARY BARTLEY | | | | 2. Date of Death Month Day Year JULY 21, 1999 | | 3. Time of Death 4:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 4021 72nd AVE. | | | | 4b. City, Town, or Location of Death LANDOVER HILLS | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 220-96-5932 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 62 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) NOV. 9, 1936 | | 9. Birthplace (State or Foreign Country) JAMAICA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County PRINCE GEORGES | | 10c. City, Town or Location LANDOVER HILLS | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 4021 72nd AVE. | | | | 10f. Zip Code 20784 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE AID | | | 16b. Kind of Business/Industry HEALTH CARE | |
| 17. Father's Name (First, Middle, Last) AUSTIN MCKENZIE | | | | 18. Mother's Name (First, Middle, Maiden Surname) EGLANTINE CROOKS | | | | |
| 19a. Informant's Name/Relationship (Type, Print) KEVIN SYDNEY BARTLEY/SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8207 DRISCOLL DR., BOWIE, MD. 20720 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY | | Date 7/26/99 | | 20c. Location - City or Town, State SUITLAND, MD. | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility MOO091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BREAST CANCER Due to (or as a consequence of): b. COLON CA Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 1 YR 6 mos |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | 29c. License number D37236 | | 29d. Date signed (Month, Day, Year) JULY 22, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLYN HENDRICKS MD 2101 MEDICAL PARK DR. SILVER SPRING MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the President's annual message to Congress. The letter is written in a formal, dignified style, and it is one of the most important documents in American history.

2. The second part of the document is a letter from the Secretary of the Treasury to the President, dated January 1, 1863. It is a very important document, as it contains the Secretary's report to the President on the state of the Treasury. The letter is written in a formal, dignified style, and it is one of the most important documents in American history.

3. The third part of the document is a letter from the Secretary of the Navy to the President, dated January 1, 1863. It is a very important document, as it contains the Secretary's report to the President on the state of the Navy. The letter is written in a formal, dignified style, and it is one of the most important documents in American history.

4. The fourth part of the document is a letter from the Secretary of the War to the President, dated January 1, 1863. It is a very important document, as it contains the Secretary's report to the President on the state of the War. The letter is written in a formal, dignified style, and it is one of the most important documents in American history.

5. The fifth part of the document is a letter from the Secretary of the Interior to the President, dated January 1, 1863. It is a very important document, as it contains the Secretary's report to the President on the state of the Interior. The letter is written in a formal, dignified style, and it is one of the most important documents in American history.

6. The sixth part of the document is a letter from the Secretary of the Agriculture to the President, dated January 1, 1863. It is a very important document, as it contains the Secretary's report to the President on the state of the Agriculture. The letter is written in a formal, dignified style, and it is one of the most important documents in American history.

7. The seventh part of the document is a letter from the Secretary of the Education to the President, dated January 1, 1863. It is a very important document, as it contains the Secretary's report to the President on the state of the Education. The letter is written in a formal, dignified style, and it is one of the most important documents in American history.

8. The eighth part of the document is a letter from the Secretary of the Commerce to the President, dated January 1, 1863. It is a very important document, as it contains the Secretary's report to the President on the state of the Commerce. The letter is written in a formal, dignified style, and it is one of the most important documents in American history.

9. The ninth part of the document is a letter from the Secretary of the Post Office to the President, dated January 1, 1863. It is a very important document, as it contains the Secretary's report to the President on the state of the Post Office. The letter is written in a formal, dignified style, and it is one of the most important documents in American history.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24291

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--------------------------|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Douglas D. Bazata | | | | 2. Date of Death Month Day Year July 15 1999 | | 3. Time of Death 12:50 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 579-10-0438 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 17, 1911 | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Chevy Chase | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 2921 Terrace Drive | | 10f. Zip Code 20815 | | |
| 10g. Citizen of What Country? U. S. A. | | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant to the Secretary of the Navy | | 16b. Kind of Business/Industry Department of Navy | | |
| 17. Father's Name (First, Middle, Last) Charles Bazata | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alma Eaglettinger | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marie-Pierre Bazata - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2921 Terrace Drive Chevy Chase, MD 20815 | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) National Crematory | | Date 7/19/99 | | 20c. Location - City or Town, State Falls Church, Virginia | | |
| 21. Signature of Funeral Service Licensee Thomas E. Hoonbaker | | | | 22. Name and Address of Facility Joseph Gawler's Sons 5130 WI Ave. N. W. Washington, D.C. 20016 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 yr | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure, Pneumonia | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Anathan MD | | | | 29c. License number 53615 | | 29d. Date signed (Month, Day, Year) 07/15/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, Congressional Lane, Rockville MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature Aruna S. Nathan | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24292

AMEND #23part1, 7/20/99, BMW, Montg. Co.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Frances Beall

2. Date of Death

Month Day Year
July 15, 1999

3. Time of Death

1:40am

4a. Facility Name (If not institution, give street and number)

Fairfield Nursing Home

4b. City, Town, or Location of Death

Crownsville

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

578-12-5574

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 7, 1918

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Riva

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

416 Westbury Drive

10f. Zip Code

21140

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

AAUW

17. Father's Name (First, Middle, Last)

Charles J. Linehan

18. Mother's Name (First, Middle, Maiden Sumama)

Ruth Simon

19a. Informant's Name/Relationship (Type, Print)

Albert P. Beall, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

416 Westbury Drive, Riva, MD 21140

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. John Episcopal Church

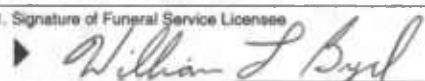
Date

July 19
1999

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CHRONIC RENAL FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 YEAR

b. Dementia

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

~~DEMENTIA~~

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

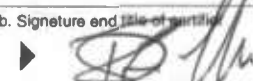
27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier



29c. License number

D38958

29d. Date signed (Month, Day, Year)

JULY 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALJEET SINGH SIDHU, M.D.P.C. 1413 ANNAPOLIS ROAD #106 ODENTON, MARYLAND 21113

State
Registrar

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24293

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gertrude C. Belshaw

2. Date of Death

Month Day Year

July 21, 1999

3. Time of Death

5:40 AM

4a. Facility Name (If not institution, give street and number)

Manor Care - Chevy Chase

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

212-05-1432

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 26, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 Maiden Choice Lane, #PV 520

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Daniel Francis Callahan

18. Mother's Name (First, Middle, Maiden Surname)

Helen Irene Martin

19a. Informant's Name/Relationship (Type, Print)

James G. Hudson (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

614 Aspen Street, NW, Washington, DC 20012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

7-22-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Delm

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Recurrent Stroke

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 days

b. Cerebrovascular Disease

Due to (or as a consequence of):

2 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

James J. Foster, M.D.

29c. License number

D04179

29d. Date signed (Month, Day, Year)

July 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James J. Foster, M.D., 5530 Wisconsin Avenue, # 925, Chevy Chase, MD 20815

State
Registrar

31. Date filed (Month, Day, Year)

JUL 22 1999

32. Registrar's Signature

Geneva B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24294

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rachel Elizabeth Boulden

2. Date of Death

Month Day Year
July 17, 1999

3. Time of Death

8:17 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

219-10-8737

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 16, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

33 Dr. Carr Road, Sunny Acres

10f. Zip Code

21901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic/Own Home

17. Father's Name (First, Middle, Last)

Ernest Wills Craig

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ann Wooleyhan

19a. Informant's Name/Relationship (Type, Print)

Audrey L. Polzer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22046
215 W. Greenway Boulevard, Falls Church, Virginia

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bethel Cemetery/July 21, 1999

Date

20c. Location - City or Town, State

Chesapeake City, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
226 E. Main Street, Cecilton, Maryland 2191323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 DAY

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH DHANJANI, MD 622 S. UNION AVE, HAVRE DE GRACE, MD 21078

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

Sandra A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24295

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Stephen Ay Bollman, Sr. | | | | 2. Date of Death Month Day Year July 12, 1999 | | 3. Time of Death 4:45 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) 201 River Road (Residence) | | | | 4b. City, Town, or Location of Death Chestertown | | 4c. County of Death Queen Anne's | |
| Funeral Director | 5. Social Security Number 217-40-7815 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 55 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 5, 1944 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Queen Anne's | | 10c. City, Town or Location Chestertown | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 201 River Road | | | | 10f. Zip Code 21620 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Manager | | | 16b. Kind of Business/Industry Rental Mart | |
| 17. Father's Name (First, Middle, Last) Roger Thurman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Elizabeth Ay | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Stephen Ay Bollman, Jr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Truslow Road, Chestertown, MD 21620 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Cemetery | | Date 7/15/99 | | 20c. Location - City or Town, State Chestertown, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Fellows, Helfenbien & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>adenocarcinoma of colon</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 2 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D16488 | | 29d. Date signed (Month, Day, Year) 7/13/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Wayne D. Benjamin M.D., Chestertown, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

March 1st 1891

Chas. J. Smith

Wm. C. Smith, Aug 1st 1891

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|--|--|---|--|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert A Brenholtz Jr. | | | | | | 2. Date of Death Month July Day 03 Year 1999 | | 3. Time of Death 1030 | | | |
| | 4a. Facility Name (If not institution, give street and number) Kent and Queen Anne's Hospital | | | | | | 4b. City, Town, or Location of Death Chestertown | | 4c. County of Death Kent | | | |
| Funeral Director | 5. Social Security Number 199-28-2631 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) June 20, 1932 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Kent | | 10c. City, Town or Location Worton | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 12630 Still Pond Creek Road | | | | 10f. Zip Code 21678 | | 10g. Citizen of What Country? USA | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | 16b. Kind of Business/Industry Education | | | | | | |
| | 17. Father's Name (First, Middle, Last) Robert Arnold Brenholtz, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mabel Ruth Steward | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mary Ellen Tyson/Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1165 Regiment Drive, N.W., Acworth, GA 30101 | | | | | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls Cemetery | | | Date 7/7/99 | | 20c. Location - City or Town, State Chestertown, MD | | | |
| | 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. CARDIO Pulmonary Arrest Due to (or as a consequence of): b. Respiratory Failure Due to (or as a consequence of): c. Metastatic Adenocarcinoma to Liver, Lung Due to (or as a consequence of): without known primary d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident, Hypertension | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) None | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier | | | | 29c. License number D23889 | | 29d. Date signed (Month, Day, Year) 7/6/99 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John E. ARABAS JR MD 948 Washington Ave, Chestertown, Md 21620 | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 07 1999 | | | 32. Registrar's Signature | | | | | | | | |

| | | | | | | | | | | | |
|---|---|----------------------------|---|--|--|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Grace May Beck | | | | 2. Date of Death Month July Day 18 Year 1999 | | | | 3. Time of Death 1149 | | |
| | 4a. Facility Name (If not institution, give street and number) Kent and Queen Anne's Hospital | | | | 4b. City, Town, or Location of Death Chestertown | | | | 4c. County of Death Kent | | |
| Funeral Director | 5. Social Security Number 214-32-0424 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) November 22, 1908 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Kent | | 10c. City, Town or Location Rock Hall | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 203 Chesapeake Villa | | | | 10f. Zip Code 21661 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own home | | | |
| 17. Father's Name (First, Middle, Last) Theodore Bosley | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence L. Sherfey | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James Nelson Culley, Jr./Grandson | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5625 Boundary Avenue, Rock Hall, Maryland 21661 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls cemetery | | Date 7/21/99 | | 20c. Location - City or Town, State Rock Hall, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Cardio Pulmonary Arrest</p> <p>Due to (or as a consequence of):</p> <p>Acute Exacerbation of Asthma</p> <p>Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 65%;"> <p>a. Cardio Pulmonary Arrest</p> <p>b. Acute Exacerbation of Asthma</p> <p>c.</p> <p>d.</p> </div> </div> | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Chronic Obstructive Pulmonary Disease</p> <p>History of Congestive Heart Failure, History of Lung Cancer</p> </div> <div style="width: 25%;"> <p>23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> </div> </div> | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input checked="" type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) none | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number 23889 | | 29d. Date signed (Month, Day, Year) 7/19/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Beaman, Jr., MD, 948 Washington Ave, Chestertown Md 21620 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24298**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|--|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ella Moore Bramble | | | | 2. Date of Death Month July 18, Day 18 , Year 1999 | | | | 3. Time of Death 6:55 PM | |
| | 4a. Facility Name (If not institution, give street and number) Dorchester General Hospital | | | | 4b. City, Town, or Location of Death Cambridge | | | | 4c. County of Death Dorchester | |
| Funeral Director | 5. Social Security Number 218-01-5255 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct 25, 1913 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Dorchester | | 10c. City, Town or Location Bishops Head | |
| To Be Completed by Funeral Director | 10e. Street and Number 1914 E. Tedious Creek Road | | | | 10f. Zip Code 21672 | | 10g. Citizen of What Country? US | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Practical Nurse | | 16b. Kind of Business/Industry State Hospital | | | |
| | 17. Father's Name (First, Middle, Last) Merritt S. Moore | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nancy Lewis | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Clara C. Hurley Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 727 Peachblossom Avenue Cambridge, Maryland 21613 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Memorial Park | | Date 7/21/99 | | 20c. Location - City or Town, State Cambridge, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Distress Due to (or as a consequence of): b. Chronic Asthmatic Bronchitis Due to (or as a consequence of): c. Multiple Aneurysms Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 4 h. 4 yrs. | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Heart Disease pericardial effusion | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA | | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 26. Place of Death (Check only one) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) N/A | | 28b. Time of Injury N/A | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred N/A | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number 211284 | | 29d. Date signed (Month, Day, Year) 7.19.99. | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann R. Wilke, MD 400 Maryland Ave, Cambridge MD 21613 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature | | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24299

PAUL
CULLENSPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Paul Frederick Cullens

2. Date of Death

Month Day Year
JULY 15, 1999

3. Time of Death

8:42P.M.

4a. Facility Name (If not institution, give street and number)

I 195 WEST (NEAR 95)

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

BALTIMORE

5. Social Security Number

215-50-2330

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct 3, 1956

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

517 Leeds Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Customer Service

16b. Kind of Business/Industry

Roofing Supplies

17. Father's Name (First, Middle, Last)

John Cullens

18. Mother's Name (First, Middle, Maiden Surname)

Joan Boudreau

19e. Informant's Name/Relationship (Type, Print)

John Cullens/ father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

489A Broadwater Road, Arnold, MD 21012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

July 19 1999

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Multiple injuries*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

7/15/99

28b. Time of Injury

8:25 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject motorist lost track of car

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Interstate 95 Baltimore County Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore H. Higgins

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE HIGGINS

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202.224.2222.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24300**
Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES COOKE | | | | 2. Date of Death Month Day Year JULY 15 1999 | | 3. Time of Death 1500 | | |
| | 4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death ANNAPOLIS | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 216-16-4096 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) MARCH 18 1924 | | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location ANNAPOLIS | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 202 CLAY STREET | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? US | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | 16b. Kind of Business/Industry BFI | | | | | |
| 17. Father's Name (First, Middle, Last) JAMES E. COOKE | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA G. JONES | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARTHA L. COOKE (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 CLAY ST. ANNAPOLIS, MD. 21401 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS | | 20c. Location - City or Town, State 7/20/99 ANNAPOLIS, MD. | | | | | |
| 21. Signature of Funeral Service Licensee <i>Larry D. Reese</i> | | | | 22. Name and Address of Facility 821 WEST STREET ANNAPOLIS, MD. WM. REESE & SONS MORTUARY, P.A. | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiac arrest</i> Due to (or as a consequence of): b. <i>Coronary artery disease</i> Due to (or as a consequence of): c. <i>Diabetes</i> Due to (or as a consequence of): d. <i>Hypertension</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 2 years 11 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>James Ruppel MD</i> | | 29c. License number 025499 | | 29d. Date signed (Month, Day, Year) 7/16/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Ruppel 180 Admiral Cochrane Dr Annapolis, MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature <i>James B. Spates</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

101 2 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #31, 7/21/99, BMW, Montg. Co

Certificate of Death

Reg. No.

99 24301

| | | | | | | | | | | |
|---|---|---------------------------|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE SAMUEL CHESKY | | | | | 2. Date of Death Month Day Year JULY 18, 1999 | | 3. Time of Death 7:30 AM | | |
| | 4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL | | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | | |
| Funeral Director | 5. Social Security Number 578-01-7909 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG. 6, 1910 | | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location SILVER SPRING | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 11706 GOODLOE ROAD | | | | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? UNITED STATES | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OFFICE CLERK | | | 16b. Kind of Business/Industry PRINTING | | |
| 17. Father's Name (First, Middle, Last) FRED CHESKY | | | | | 18. Mother's Name (First, Middle, Maiden Surname) LOUISE HABERLY | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MILDRED E. CHESKY (WIFE) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11706 GOODLOE RD. SILVER SPRING MARYLAND 20906 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOHNS-FOREST GLEN | | Date 7-20-99 | | 20c. Location - City or Town, State SILVER SPRING, MD. | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility HINES-RINALDI F.H. INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING MD. 20904 | | | | | |
| Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | |
| e. PNEUMONIA Due to (or as a consequence of): | | | | | | | | | | |
| b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): | | | | | | | | | | |
| c. PYLORIC STENOSIS Due to (or as a consequence of): | | | | | | | | | | |
| d. | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier  M.D. | | | | | 29c. License number D-27660 | | 29d. Date signed (Month, Day, Year) 7/20/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALPANA GOSWAMI M.D. 10901 CONNETT AVE, KENSINGTON, MD 20895 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 | | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

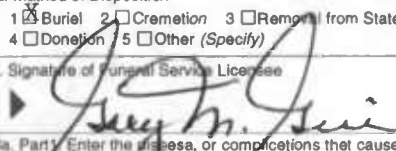

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24302

| | | | | | | | | |
|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Lou Chory | | | | 2. Date of Death Month Day Year July 15, 1999 | | 3. Time of Death 12:25 PM | |
| | 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital | | | | 4b. City, Town, or Location of Death Rockville MD | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 412-50-4827 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb 17, 1934 | |
| | 9. Birthplace (State or Foreign Country) Tennessee | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Derwood | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | | 10b. County Montgomery | | | 10c. City, Town or Location Derwood | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 10e. Street and Number 6901 Horizon Terrace | | | 10f. Zip Code 20855 | | |
| 10g. Citizen of What Country? United States | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | 17. Father's Name (First, Middle, Last) Greenie Jack | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Cheatham | | | 19a. Informant's Name/Relationship (Type, Print) Joseph L. Chory, husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6901 Horizon Terrace, Derwood, MD 20855 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | | 20c. Location - City or Town, State Silver Spring, MD | | |
| 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD 20877 | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Non Small Cell Carcinoma of Right Lung Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | 23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | | 28b. Time of Injury M | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier James A. Brown, MD | | |
| 29c. License number D07285 | | | 29d. Date signed (Month, Day, Year) July 15, 1999 | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Brown, MD 9707 Medical Center Drive, Rockville, MD 20850 | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24303

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Magda Comsky | | 2. Date of Death Month Day Year July 19, 1999 | | 3. Time of Death 7:19 AM |
| | 4a. Facility Name (If not institution, give street and number) 412 Kimblewick Drive | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 109-16-2203 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | 8. Date of Birth (Month, Day, Year) March 3, 1910 | 9. Birthplace (State or Foreign Country) Yugoslavia |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State Florida | 10b. County Palm Beach | 10c. City, Town or Location West Palm Beach | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number 2800 North Flagler Drive | | 10f. Zip Code 33407 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant | | 16b. Kind of Business/Industry Real Estate | | |
| | 17. Father's Name (First, Middle, Last) Robert Rado | | 18. Mother's Name (First, Middle, Maiden Surname) Ida Bun | | |
| | 19a. Informant's Name/Relationship (Type, Print) Miriam Gray (daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Kimblewick Drive, Silver Spring, Maryland 20904 | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Location - City or Town, State 7/20/99 Beltsville, Maryland |
| | 21. Signature of Funeral Service Licensee  M00956 | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Cerebrovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 9 months years | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Daughter's residence | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and Title of Certifier  29c. License number D10287 29d. Date signed (Month, Day, Year) July 19, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Brandis Marsh, M.D., 106 Irving Street, NW, #116, Washington, DC 20010 | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24304**
Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Frances Pauline Cooper | | | | 2. Date of Death Month Day Year July 14, 1999 | | 3. Time of Death 2:45 a.m. | | |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 109-26-9504 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) April 2, 1905 | | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 14508 Homecrest Road | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses' Aide | | 16b. Kind of Business/Industry Hospital/Home Care | | 17. Father's Name (First, Middle, Last) Gregor Planinsek | | 18. Mother's Name (First, Middle, Maiden Surname) Fannie Grablovitz | |
| 19a. Intomant's Name/Relationship (Type, Print) (daughter) Constance C. Hendrickson | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8400 Carderock Drive, Bethesda, Maryland 20817 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Location - City or Town, State 7/17/99 Beltsville, Maryland | |
| 21. Signature of Funeral Service Licensee  M00956 | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STROKE | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 7/14/99 | | 28b. Time of Injury M | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred. | | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D26259 | | 29d. Date signed (Month, Day, Year) 7/16/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ava A. Kaufman M.D. 4930 Del Ray Ave #403 Bethesda | | 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature  | | 33. Date of Death 20814 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

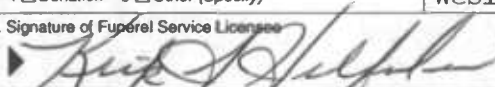
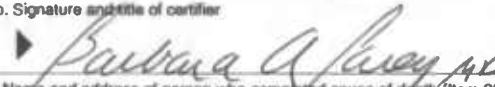
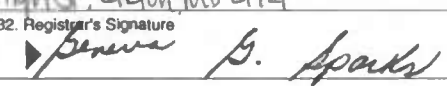
Physician
/Medical
Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24305
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Hazel Joiner Carter</u> | | | | 2. Date of Death Month <u>July</u> Day <u>23</u> Year <u>1999</u> | | | | 3. Time of Death <u>0210</u> | | |
| | 4a. Facility Name (If not institution, give street and number) <u>Sunrise Nursing Home</u> | | | | 4b. City, Town, or Location of Death <u>Elkton</u> | | | | 4c. County of Death <u>Cecil</u> | | |
| Funeral Director | 5. Social Security Number <u>216-10-2013</u> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>89</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>August 31, 1909</u> | | 9. Birthplace (State or Foreign Country) <u>Rock Hall, MD</u> | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State <u>Maryland</u> | | 10b. County <u>Kent</u> | | 10c. City, Town or Location <u>Rock Hall</u> | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number <u>5708 Liberty Street</u> | | | | 10f. Zip Code <u>21661</u> | | | | 10g. Citizen of What Country? <u>USA</u> | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Cook</u> | | | | 16b. Kind of Business/Industry <u>Public School System</u> | | | |
| 17. Father's Name (First, Middle, Last) <u>David W. Joiner</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Elizabeth Minner</u> | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Mike Joiner</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6528 Rock Hall Road, Chestertown, MD 21620</u> | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Wesley Chapel Cemetery</u> | | Date <u>7/26/99</u> | | 20c. Location - City or Town, State <u>Rock Hall, Maryland</u> | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility <u>Fellows, Helfenbein & Newnam Funeral Home, P.A.</u> <u>130 Speer Road, Chestertown, MD 21620</u> | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) <u>Myocardial Infarction</u> Due to (or as a consequence of): | | | | | | | | | | <u>2 min</u> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CVA</u> <u>Dementia</u> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number <u>025915</u> | | | | 29d. Date signed (Month, Day, Year) <u>7-23-99</u> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Barbara A. Pary MD 111 W. High St. Elkton MD 21924</u> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>JUL 23 1999</u> | | 32. Registrar's Signature  | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24306

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES HENRY COE

2. Date of Death

Month
JULYDay
15Year
1999

3. Time of Death

12:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6746 QUAKER NECK ROAD

4b. City, Town, or Location of Death

CHESTERTOWN

4c. County of Death

KENT

5. Social Security Number

216-51-1260

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

JULY 23, 1920

9. Birthplace (State or Foreign Country)

ENGLAND

Usual Residence of Decedent

10a. State

MD

10b. County

KENT

10c. City, Town or Location

CHESTERTOWN

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

200 HADAWAY DRIVE

10f. Zip Code

21620

10g. Citizen of What Country?

ENGLAND

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ENGINEERING FITTER

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

SAMUEL

COE

18. Mother's Name (First, Middle, Maiden Surname)

VICTORIA

TALBOT

19a. Informant's Name/Relationship (Type, Print)

LESLEY MURRAY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6746 QUAKER NECK ROAD CHESTERTOWN MD 21620

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATORY July 16, 1999 CHESTER, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Marvin V. Williams, Jr.

22. Name and Address of Facility

MARVIN V. WILLIAMS, JR. FUNERAL SERVICE
205 GREEN HERON WAY CHESTERTOWN, MD 2162023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Cardiopulmonary Arrest

Due to (or as a consequence of):

b.

Congestive Heart Failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type II Diabetes, Seizure Disorder,
Severe Arterio Sclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

None

28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

J.C. Andrews, M.D.

29c. License number

D23889

29d. Date signed (Month, Day, Year)

7/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Whit. A. Adams, Jr., M.D., 948 Washington Ave

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principles of wave mechanics.

In the second part of the paper, the author discusses the application of the theory of the structure of the atom to the study of the properties of matter. It is shown that the theory of the structure of the atom can be used to explain the properties of matter, such as the properties of the elements and the properties of the compounds.

The third part of the paper is devoted to a discussion of the experimental methods used to study the structure of the atom. It is shown that the experimental methods used to study the structure of the atom are based on the principles of wave mechanics, and that the experimental methods used to study the structure of the atom are based on the principles of wave mechanics.

The fourth part of the paper is devoted to a discussion of the results of the experiments. It is shown that the results of the experiments are in good agreement with the predictions of the theory of the structure of the atom, and that the results of the experiments are in good agreement with the predictions of the theory of the structure of the atom.

The fifth part of the paper is devoted to a discussion of the conclusions of the experiments. It is shown that the conclusions of the experiments are in good agreement with the predictions of the theory of the structure of the atom, and that the conclusions of the experiments are in good agreement with the predictions of the theory of the structure of the atom.

The sixth part of the paper is devoted to a discussion of the future of the theory of the structure of the atom. It is shown that the future of the theory of the structure of the atom is bright, and that the future of the theory of the structure of the atom is bright.

The seventh part of the paper is devoted to a discussion of the bibliography. It is shown that the bibliography is in good agreement with the predictions of the theory of the structure of the atom, and that the bibliography is in good agreement with the predictions of the theory of the structure of the atom.

The eighth part of the paper is devoted to a discussion of the index. It is shown that the index is in good agreement with the predictions of the theory of the structure of the atom, and that the index is in good agreement with the predictions of the theory of the structure of the atom.

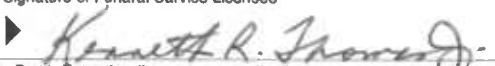


The ninth part of the paper is devoted to a discussion of the appendix. It is shown that the appendix is in good agreement with the predictions of the theory of the structure of the atom, and that the appendix is in good agreement with the predictions of the theory of the structure of the atom.

The tenth part of the paper is devoted to a discussion of the conclusion. It is shown that the conclusion is in good agreement with the predictions of the theory of the structure of the atom, and that the conclusion is in good agreement with the predictions of the theory of the structure of the atom.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24307
Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|---|--|---|---|--|--------------------------|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DONNA JEAN CARMINE | | | | 2. Date of Death Month Day Year July 20 1999 | | | | 3. Time of Death 0450 | | | |
| | 4a. Facility Name (If not institution, give street and number) Dorchester General Hospital | | | | 4b. City, Town, or Location of Death Cambridge | | | | 4c. County of Death Dorchester | | | |
| Funeral Director | 5. Social Security Number 218-48-6743 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 51 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 17 1948 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Dorchester | | 10c. City, Town or Location Cambridge | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 212 Virginia Ave. | | | | 10f. Zip Code 21613 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) senior product test operator | | | | 16b. Kind of Business/Industry appliance mfg. | | | |
| | 17. Father's Name (First, Middle, Last) William Purnell Todd | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nettie Mae Lloyd | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Donna Carpenter - daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 51, trappe MD 21673 | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) East New Market Cemetery | | Data 7-22-99 | | 20c. Location - City or Town, State East New Market Md. | | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. Metastatic Cancer of Cervix Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 12 mos. | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 026388 | | | | 29d. Date signed (Month, Day, Year) 7-20-1999 | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Michael Fadden MD 302 Collins Hurlock Md 21643 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 | | | | 32. Registrar's Signature  | | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24308

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ETHEL GOLDSTEIN DWORETZKY | | | | 2. Date of Death Month Day Year 07.14.1999 | | 3. Time of Death 4:50PM | | |
| | 4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | | |
| Funeral Director | 5. Social Security Number 263.82.4086 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 95 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) AUG. 4, 1903 | 9. Birthplace (State or Foreign Country) FLORIDA | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location ROCKVILLE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 6121 MONTROSE ROAD | | | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? usa | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last) MICHAEL GOLDSTEIN | | | | 18. Mother's Name (First, Middle, Maiden Surname) IDA MORRIS | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) ADELE SAMLER/NIECE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10705 GLOXINIA DRIVE, ROCKVILLE, MARYLAND 20852 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GDNS | | Date 7.18.99 | | 20c. Location - City or Town, State FALLS CHURCH, VIRGINIA | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA, BOTH LOWER LOBES | | | | | | | Approximate Interval Between Onset and Death | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D18084 | | 29d. Date signed (Month, Day, Year) JULY 14, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24309

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Marian

Dempsey

2. Date of Death

Month Day Year
July 13, 1999

3. Time of Death

1:19AM

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

165-18-6549

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 27, 1917

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

303 Adclare Road

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Executive
to the President

16b. Kind of Business/Industry

American Institute
of Architects

17. Father's Name (First, Middle, Last)

William Morris Fay

18. Mother's Name (First, Middle, Maiden Surname)

Carolyn Runner

19a. Informant's Name/Relationship (Type, Print)

William M. Dempsey - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

100 Spear St. #805 San Francisco, CA 94105

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

National Crematory

Date

7/17/99 Falls Church, VA

21. Signature of Funeral Service Licensee

Thomas E. Honnaker

22. Name and Address of Facility

Joseph Gawler's Sons
5130 WI Ave. NW Washington, D. C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Atherosclerosis

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joel Schulman MD

29c. License number

D 20516

29d. Date signed (Month, Day, Year)

July 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel Schulman MD., 9401 Old Georgetown Rd., Bethesda, MD 20814

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Page 1 of 1

Subject: [Illegible]

Date: [Illegible]

Location: [Illegible]

Time: [Illegible]

Weather: [Illegible]

Remarks: [Illegible]

Signature: [Illegible]

Title: [Illegible]

Organization: [Illegible]

Address: [Illegible]

City: [Illegible]

State: [Illegible]

Zip: [Illegible]

Phone: [Illegible]

Fax: [Illegible]

E-mail: [Illegible]

Web: [Illegible]

Notes: [Illegible]

Comments: [Illegible]

Attachments: [Illegible]

References: [Illegible]

Links: [Illegible]

Images: [Illegible]

Files: [Illegible]

Forms: [Illegible]

Tools: [Illegible]

Services: [Illegible]

Products: [Illegible]

Support: [Illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24310

| | | | | | | | | |
|---|---|-----------------------------|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Edward Davis, Jr. | | | | 2. Date of Death Month Day Year July 17, 1999 | | 3. Time of Death 3:51 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) Futurecare Chesapeake | | | | 4b. City, Town, or Location of Death Arnold | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 212-66-1501 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 45 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan 19, 1954 | 9. Birthplace (State or Foreign Country) Japan |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1161 Ramblewood Drive | | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | 16b. Kind of Business/Industry High School Educator | |
| 17. Father's Name (First, Middle, Last) James E. Davis, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Betsy Johnson | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Davis / wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1161 Ramblewood Drive, Annapolis, MD 21401 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) entombment | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Mem. Park | | Date July 21 1999 | 20c. Location - City or Town, State Cambridge, MD | | |
| 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NO ENDO CARCINOMA OF UNKNOWN ORIGIN 22 mo Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 22 mo |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier | | | 29c. License number D08118 | | 29d. Date signed (Month, Day, Year) 7/19/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLEY P. WATKINS, MD ANNA, MD 21401 900 BESTGATE RD | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | | 32. Registrar's Signature | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

JOSHA
DEEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24311

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSHUA TYLER DEEN

2. Date of Death

Month Day Year
JULY 15, 1999

3. Time of Death

1:04P.M.

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

216-39-9681

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

5

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 25, 1993

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8509 Tahona Drive

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

1

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Jeremy F. Deen

18. Mother's Name (First, Middle, Maiden Surname)

Helen J. Shana

19a. Informant's Name/Relationship (Type, Print)

Jeremy F. Deen (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8509 Tahona Drive Silver Spring, Maryland 20903

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/19/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☒ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

7/15/99

28b. Time of Injury

1225

28c. Injury at Work?

☐ Yes ☒ No

28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Parking lot

28e. Describe how injury occurred

Pedestrian struck by auto

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8750 Arliss St., Silver Spring, MD

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. A. Henlock, MD

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24312

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry A. Drak

2. Date of Death
Month Day Year

July 20, 1999

3. Time of Death

6:45am

4a. Facility Name (If not Institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

175-16-1133

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Sept. 13, 1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

1307 Ruppert Road

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Railway Clerk

16b. Kind of Business/Industry

Conrail

17. Father's Name (First, Middle, Last)

John Drackiewicz

18. Mother's Name (First, Middle, Maiden Surname)

Stephanie Ganczak

19a. Informant's Name/Relationship (Type, Print)

Mary Drak/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1307 Ruppert Road, Silver Spring, MD 20903

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Calvary Cemetery

Date

July 24
1999

20c. Location - City or Town, State

Pittsburgh, PA

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Barry N. Rosenbaum

29c. License number

D09834

29d. Date signed (Month, Day, Year)

July 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry N. Rosenbaum 3720 Farragut Ave., Kensington, MD 20895

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24313

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | | | |
|--|--|--|--|--|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last) Essie J. Davis | | | | 2. Date of Death Month July Day 21 Year 1999 | | 3. Time of Death 3:19 am | |
| 4a. Facility Name (If not institution, give street and number) 14006 Baden Westwood Rd | | | | 4b. City, Town, or Location of Death Brandywine | | 4c. County of Death Prince Georges | |
| 5. Social Security Number 212-38-4122 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 93 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) January 4, 1906 | |
| 9. Birthplace (State or Foreign Country) South Carolina | | | | | | | |

Funeral
Director

| | | | | | | |
|-------------------------------|--|--------------------------------------|--|--|--|--|
| 10a. State Maryland | | 10b. County Prince Georges | 10c. City, Town or Location Brandywine | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
|-------------------------------|--|--------------------------------------|--|--|--|--|

To Be Completed by Funeral Director

| | | | | | |
|--|--|---|--|--|--|
| 10e. Street and Number 14006 Baden Westwood RD | | 10f. Zip Code 20613 | | 10g. Citizen of What Country? U.S.A | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cosmetologist | |
| 16b. Kind of Business/Industry Cosmetology | | 17. Father's Name (First, Middle, Last) Unknown | | 18. Mother's Name (First, Middle, Maiden Surname) Unknown | |

| | | | |
|---|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print) Mckinley Bright- Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14006 Baden Westwood Rd, Brandywine Maryland 20613 | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Thomas Ch Cem. 7/30/99 | |
| 20c. Location - City or Town, State Brandywine MD | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility Adams Funeral Home P.A. Aquasco MD 20608 | | | |

Physician
/Medical
Examiner

| | | | |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CORONARY ARTERY DISEASE 714v Due to (or as a consequence of): CEREBROVASCULAR DISEASE. 714v Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
|--|--|--|--|

| | | | |
|---|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EDEMA CARDIAC ARRHYTHMIA | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | |
|---|--|---|--|
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 7/30/99 | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |

| | | | |
|---|--|--|--|
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier RBSamra MD | |
| 29c. License number D27744 | | 29d. Date signed (Month, Day, Year) 7.21.99 | |

| | |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJ SANTANI 9131 DISCATAWAY RD CLINTON | |
|---|--|

State
Registrar

| | | | |
|---|--|-------------------------------|--|
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | 32. Registrar's Signature | |
|---|--|-------------------------------|--|

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible handwriting]

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24314

AMEND #1 PER MD. G775 9-2-99 J.A.

Physician
/Medical
Examiner

Funeral
Director

| | | | | |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Dorothy JEAN Dashiells | | 2. Date of Death Month 7 Day 5 Year 99 | | 3. Time of Death 6:41 P.M. |
| 4a. Facility Name (If not institution, give street and number) GARRETT COUNTY MEMORIAL HOSPITAL | | 4b. City, Town, or Location of Death OAKLAND | | 4c. County of Death GARRETT |
| 5. Social Security Number 212-28-8729 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | 8. Date of Birth (Month, Day, Year) DEC 28, 1932 | 9. Birthplace (State or Foreign Country) OHIO |
| Usual Residence of Decedent | | | | |
| 10a. State WV | 10b. County PRESTON | 10c. City, Town or Location TERRA ALTA | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number RT.2 BOX 151-1B | | 10f. Zip Code 26764 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING ASSISTANT | | 16b. Kind of Business/Industry HEALTH CARE | | |
| 17. Father's Name (First, Middle, Last) WESLEY M. PURTEE | | 18. Mother's Name (First, Middle, Maiden Surname) FANNIE MAE BOWERS | | |
| 19a. Informant's Name/Relationship (Type, Print) RAYMOND DASHEILLS - HUSBAND | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT.2 BOX 151-1B TERRA ALTA, WV 26764 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) FAITH CEMETERY | | 20c. Location - City or Town, State 7/8/99 TERRA ALTA, WV |
| 21. Signature of Funeral Service Licensee  MOO167 | | 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): b. Atherosclerotic coronary vasc. dis Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 5 mins unknown |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier  | | 29c. License number 042464 | | 29d. Date signed (Month, Day, Year) 7/5/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. SAVOPOULOS, M.D. 1104 E. STATE ST. TERRA ALTA, WV 26764 | | | | |
| 31. Date filed (Month, Day, Year) JUL - 7 1999 | | 32. Registrar's Signature  | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24315

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frederick John Eller

2. Date of Death

Month Day Year
July 8th 1999

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

Crofton Convalescent & Rehab. Ctr.

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

507-18-0588

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

6. Date of Birth

(Month, Day, Year)
Dec. 12, 1918

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2569 Forest Knoll Road

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: 1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

V.P. Sales-East Region

16b. Kind of Business/Industry

Foods

17. Father's Name (First, Middle, Last)

Nick Eller

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Seberger

19a. Informant's Name/Relationship (Type, Print)

Mabel E. Eller/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2569 Forest Knoll Road Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Veterans Cemetery

Date: 7/12/99

20c. Location - City or Town, State

Crownsville, MD.

21. Signature of Funeral Service Licensee

C. Brian Powell

22. Name and Address of Facility John M. Taylor Funeral Home

147 Duke of Gloucester St. Annapolis 21401

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. chronic obstructive pulmonary disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Impaired heart failure, Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Eller MD

29c. License number

D38958

29d. Date signed (Month, Day, Year)

7/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daljeet Singh Sidhu 1413 Annapolis Road 106 ODENTON MD 21113

State
Registrar

31. Date filed (Month, Day, Year)

JUL 12 1999

32. Registrar's Signature

B. Spade

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1000 3 1 JUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24316

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

William Keith Enright

2. Date of Death

Month
JulyDay
10Year
1999

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

2924 Davidsonville Road

4b. City, Town, or Location of Death

Davidsonville

4c. County of Death

Anne Arundel

5. Social Security Number

356-30-9362

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 9, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2924 Davidsonville Road

10f. Zip Code

21035

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 195613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Real Estate Agent

16b. Kind of Business/Industry

R.E. Sales

17. Father's Name (First, Middle, Last)

William K. Enright, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Dolores Finn

19a. Informant's Name/Relationship (Type, Print)

Gail M. Enright/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD
2924 Davidsonville Rd. Davidsonville 21035

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date
7/12/99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

J. E. Buell

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Cardiac Insufficiency minutes

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William P. Jones, MD Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

7/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

JUL 12 1999

32. Registrar's Signature

B. Jones

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenya Eldridge

2. Date of Death

Month

Day

Year

7

4

1999

1700

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

220-84-2405

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

24 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 7 1974

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

425 Captains Circle Apt. A

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

Collage (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

North Arundel Hospital

17. Father's Name (First, Middle, Last)

Kenneth Eldridge

18. Mother's Name (First, Middle, Maiden Summa)

Elenor Williams

19a. Informant's Name/Relationship (Type, Print)

Kenneth Eldridge (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8200 Stewarton Ct. Severn, Md. 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHEWS CHURCH CEMETERY

Date

7-9-99

20c. Location - City or Town, State

Owensville, Md.

21. Signature of Funeral Service Licensee

Harry D. Reese

22. Name and Address of Facility

Wm. Reese And Sons Mortuary, P.A.
821 West St. Annapolis, Md. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PROBABLE PULMONARY EMBOLUS

IMMEDIATE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

RECENT STAPHYLOCOCCUS BACTEREMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Clance

29c. License number

D38328

29d. Date signed (Month, Day, Year)

7-5-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

180 ADMIRAL COCHRANE DR ANNAPOLIS MD M. CLANCE

31. Date filed (Month, Day, Year)

JUL 9 1999

32. Registrar's Signature

B. Sparks

21401

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Page 1 of 1

Subject: [Illegible]

Date: [Illegible]

Reference: [Illegible]

Location: [Illegible]

Time: [Illegible]

Page 1 of 1

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24319

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) LEOLA AGNES HILL EDELEN | | | | 2. Date of Death Month Day Year JULY 22 1999 | | 3. Time of Death 5:55 A.M. | |
| 4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER | | | | 4b. City, Town, or Location of Death LAPLATA | | 4c. County of Death CHARLES | |
| 5. Social Security Number 216-16-0314 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 15, 1916 | |
| 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County CHARLES | | 10c. City, Town or Location NEWBURG | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 14630 SOUTH CUCKOLDS CREEK ROAD | | 10f. Zip Code 20664 | | 10g. Citizen of What Country? UNITED STATES | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) HOMEMAKER | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry PRIVATE | | 17. Father's Name (First, Middle, Last) JOHN HILL | |
| 18. Mother's Name (First, Middle, Maiden Surname) BERTHA GREEN HILL | | 19a. Informant's Name/Relationship (Type, Print) RUTH T. EDELEN / DAUGHTER-IN-LAW | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12005 CUCKOLDS CREEK ROAD NEWBURG, MARYLAND 20664 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY GHOST CHURCH CEMETERY | | 20c. Date 7/26/99 | | 20d. Location - City or Town, State ISSUE, MARYLAND | | 21. Signature of Funeral Service Licensee  LEON THORNTON | |
| 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. | | 22. Name and Address of Facility 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): sepsis Due to (or as a consequence of): Hypovolemia Due to (or as a consequence of): Decubitus ulcers | | Approximate Interval Between Onset and Death 11 days 15 days 15 days 1 year | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Herpes Zoster, Alzheimer's Dementia, Arthritic Contractures, Hypoxemia, Anemia, Urrosepsis, Hyponatremia | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D-08370 | |
| 29d. Date signed (Month, Day, Year) 7/22/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL E. PRITCHETT MD 118 LAGRANGE AVE. P.O. BOX 1317 LAPLATA MD. 20646 | | 31. Date filed (Month, Day, Year) JUL 23 1999 | | 32. Registrar's Signature  | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24320

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN E. ELLINGSEN, Sr.

2. Date of Death

Month Day Year
July 24 1999 1931

3. Time of Death

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

220-01-0228

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7/31/2000

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

MD

10f. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1032 North Heritage Court

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stationary Engineer

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Hans Torvald Ellingsen

18. Mother's Name (First, Middle, Maiden Surname)

Olga Kristina Johansen

19a. Informant's Name/Relationship (Type, Print)

Olga Penrod/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 1 Box 362L, Seaford, DE 19973

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

7/29

20c. Location - City or Town, State

Easton, Maryland

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home
P.O. Box 43, Federalsburg, MD 21632

23a. Per1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Heart Failure

Due to (or as a consequence of):

4 Days

b.

Ischemia

Due to (or as a consequence of):

4 Days

c.

Coronary Artery Disease

Due to (or as a consequence of):

40 Years

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Burdick MD

29c. License number

DO054576

29d. Date signed (Month, Day, Year)

07/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rachel Burdick 101 Thompson Street Saint Michaels, Maryland

31. Date filed (Month, Day, Year)

JUL 27 1999

32. Registrar's Signature

Beyona B. Sparks

State
Registrar

John Ellingsen

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

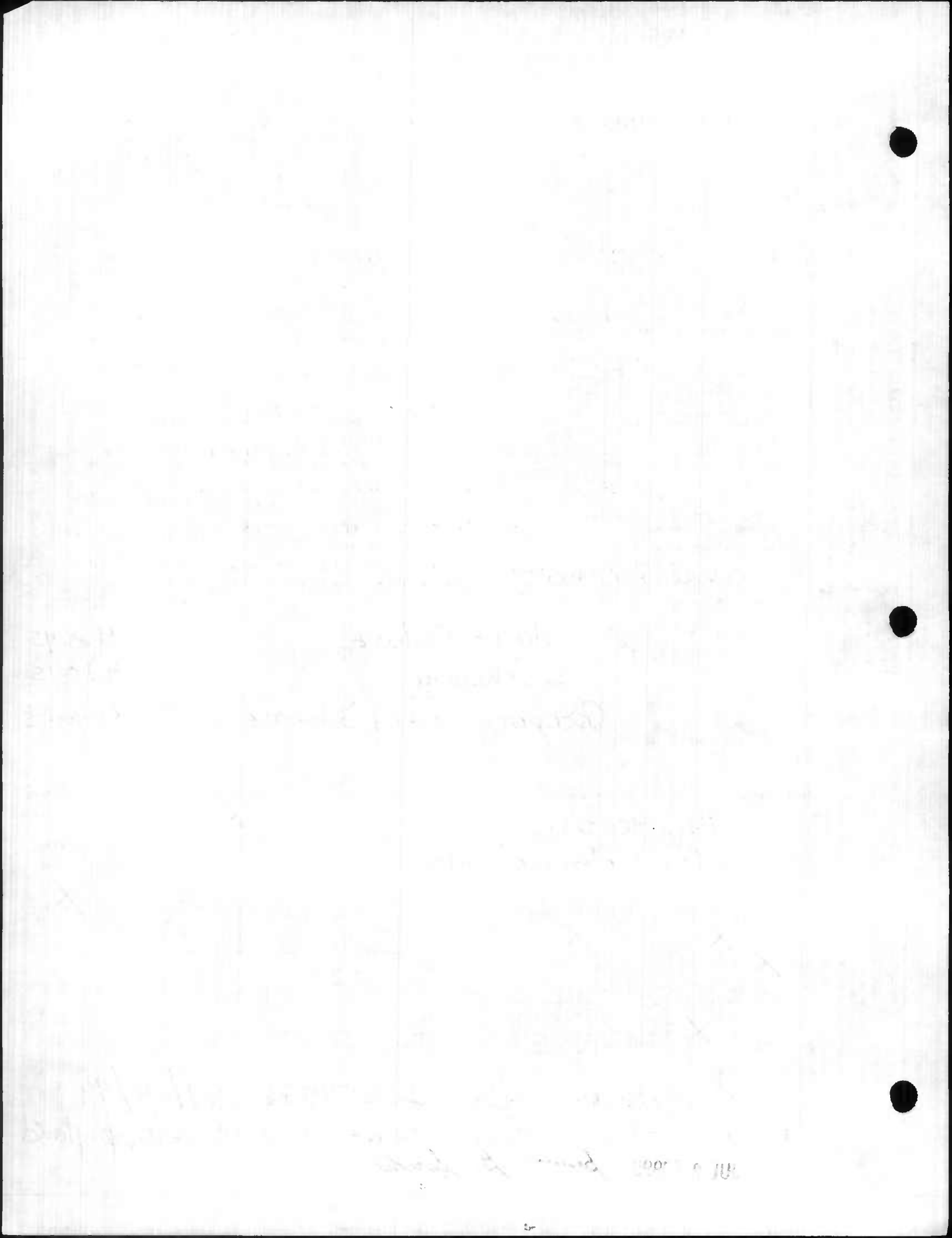
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



99-3999-031

99-154

ELIZABETH FEROLDI

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24321

| | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELIZABETH WOODWARD FEROLDI | | | | | | 2. Date of Death Month Day Year JULY 9, 1999 | | 3. Time of Death 3:42P.M. | |
| | 4a. Facility Name (If not institution, give street and number) NEBEL STREET ON RANDOLPH ROAD | | | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 089-40-9105 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 40 Yrs. | | 8. Date of Birth (Month, Day, Year) March 17, 1959 | | 9. Birthplace (State or Foreign Country) New York | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Virginia | | 10b. County Fairfax | | 10c. City, Town or Location Vienna | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 9850 Hidden Estates Cove | | | | 10f. Zip Code 22181-6090 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Account Executive | | | | 16b. Kind of Business/Industry Hewlett-Packard | | |
| 17. Father's Name (First, Middle, Last) Kenneth G. Woodward | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jean Powell | | | | |
| 19a. Informant's Name/Relationship (Type, Print) John R. Feroldi/Husband | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9850 Hidden Estates Cove, Vienna, Va. 22181-6090 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | | Date 7/14/99 | | 20c. Location - City or Town, State Alexandria, Va. | | |
| 21. Signature of Funeral Service Licensee Betty L. Psatelli | | | | | | 22. Name and Address of Facility MONEY & KING VIENNA FUNERAL HOME, INC. 171 W. Maple Ave., Vienna, Va. 22180 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) TRAIN TRACKS | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) 7-9-99 | | 28b. Time of Injury 1542 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject struck by Train | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Railway Tracks | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Nebel Street | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier David R. Fowler | | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 10, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24322

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Darrell W. Fletcher | | | | 2. Date of Death Month Day Year July 9, 1999 | | 3. Time of Death 5:25 am | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 219-12-4383 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 72 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) August 3, 1926 | 9. Birthplace (State or Foreign Country) Washington DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 111 Lock Leven Drive | | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer | | | 16b. Kind of Business/Industry Corporate Sales Mgr. | |
| 17. Father's Name (First, Middle, Last) Thomas Fletcher | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nell Williams | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jaclynn Fletcher / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Great Lake Drive, Annapolis, MD 21403 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date July 15 1999 | | 20c. Location - City or Town, State Baltimore, MD |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. end stage dilated cardiomyopathy Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 2 d |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypoglycemia, chronic obstructive pulmonary dz, sleep apnea, | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D38158 | | 29d. Date signed (Month, Day, Year) 7/9/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 Medical Parkway, Annapolis MD 21401, Dr Lisa DiMarco | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | | | 32. Registrar's Signature | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

[Faint, illegible handwritten text covering the majority of the page]

22/10/72
27/10/72
28/10/72
29/10/72
30/10/72
31/10/72
1/11/72
2/11/72
3/11/72
4/11/72
5/11/72
6/11/72
7/11/72
8/11/72
9/11/72
10/11/72
11/11/72
12/11/72
13/11/72
14/11/72
15/11/72
16/11/72
17/11/72
18/11/72
19/11/72
20/11/72
21/11/72
22/11/72
23/11/72
24/11/72
25/11/72
26/11/72
27/11/72
28/11/72
29/11/72
30/11/72
1/12/72
2/12/72
3/12/72
4/12/72
5/12/72
6/12/72
7/12/72
8/12/72
9/12/72
10/12/72
11/12/72
12/12/72
13/12/72
14/12/72
15/12/72
16/12/72
17/12/72
18/12/72
19/12/72
20/12/72
21/12/72
22/12/72
23/12/72
24/12/72
25/12/72
26/12/72
27/12/72
28/12/72
29/12/72
30/12/72
31/12/72

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24323

AMEND#1 PER PHY. AACO HEALTH DEPT 7/14/99

Certificate of Death

cmh

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|---|---|----|------------------|---|----|---------------------------|----------------|----|--|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEON BROWN FLEMING Fleming Jr. | | | | | | 2. Date of Death Month Day Year JULY 10, 1999 | | 3. Time of Death 4 A.M. | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) HOLY CROSS NURSING AND REHABILITATION CENTER BURTONSVILLE | | | | | | 4b. City, Town, or Location of Death MONTGOMERY | | 4c. County of Death MONTGOMERY | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 241-30-6331 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 5, 1927 | | 9. Birthplace (State or Foreign Country) North Carolina | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George | | 10c. City, Town or Location Hyattsville | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 10e. Street and Number 4005 Remington Ct. | | | | 10f. Zip Code 20782 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Year or Dates: 1945-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor | | | 16b. Kind of Business/Industry University | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Leon B. Fleming Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Louise | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sallie K. Fleming (wife) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Remington Ct. Hyattsville, MD 20782 | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Elmwood Cemetery N.C. | | Date 7/14/99 | | 20c. Location - City or Town, State Henderson, N.C. | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester st. Annapolis, MD 21401 | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Pneumonia</td> <td>Approximate Interval Between Onset and Death 48 Hr.</td> </tr> <tr> <td>b.</td> <td>Parkinsons Disease</td> <td>4 Years</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Pneumonia | Approximate Interval Between Onset and Death 48 Hr. | b. | Parkinsons Disease | 4 Years | c. | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Pneumonia | Approximate Interval Between Onset and Death 48 Hr. | | | | | | | | | | | | | | | | | | | |
| | b. | Parkinsons Disease | 4 Years | | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D41931 | | 29d. Date signed (Month, Day, Year) July 12, 1999 | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Shumacher MD 2309 Shorefield Rd. Wheaton, MD 20902 | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24324

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Disney Finegan

2. Date of Death

July 8, 1999

3. Time of Death

4:00 am

4a. Facility Name (If not institution, give street and number)

Oak Lodge Assisted Living

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

217-05-7787

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 26, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

7753 Outing Avenue

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Enoch Pratt Library

17. Father's Name (First, Middle, Last)

Walter McCrea Disney

18. Mother's Name (First, Middle, Maiden Surname)

Florence Johnson

19a. Informant's Name/Relationship (Type, Print)

Walter Severn JONES NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5531 Wells Cove Drive, St. Leonard, MD 20685

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Date

July 12 1999

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I: Enter the disease or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Anterior Septal Cardio Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Vascular accident

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Assisted Living

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

042820

29d. Date signed (Month, Day, Year)

7/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher deBorja MD 3708 Mountain Rd. Pasadena Md 21122

31. Date filed (Month, Day, Year)

JUL 09 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 37 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24325

Amend #5, 10e, 7/26/99, BMW, Montg. Co.

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Bernice Smith Ferrell | | | | 2. Date of Death Month Day Year July 18, 1999 | | | | 3. Time of Death 9:15am | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death ROCKVILLE | | | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 231-24-5646 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) May 27, 1927 | | 9. Birthplace (State or Foreign Country) Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 319 Westside Drive #201 | | | | 10f. Zip Code 20878 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Howe Alvin Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie T. Anderson | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Yolanda Howard (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10044 Trafalgar Square Gaithersburg, Md. 20877 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park | | Date July 21, 1999 | | 20c. Location - City or Town, State Rockville, Md. | | | |
| | 21. Signature of Funeral Service Licensee Curtis E. Day | | | | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Severe Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 1 day 1 year | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Myocardial Infarction Pneumonia | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| State Registrar | 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Junction MD | | 29c. License number D051714 | | 29d. Date signed (Month, Day, Year) July 18, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JATINDER - S. SEKHON, 2401 Research Blvd #102, Rockville, MD 20850 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature Geneva S. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24326

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Albert G. Fiedler

2. Date of Death

Month Day Year
July 19, 1999

3. Time of Death

3:15 am

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-58-2560

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

102

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 4, 1897

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3383 South Leisure World Boulevard #B1

10f. Zip Code

20906-1758

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW I

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Gustau Fiedler

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Jakemite

19a. Informant's Name/Relationship (Type, Print)

Sharon Heckert/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

870 Cala Basas Road Watsonville, California 95076

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery Crematorium Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy

7557 Wisconsin Avenue Chase, Inc.

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

24 Hours

b. Pneumonia

Due to (or as a consequence of):

72 Hours

c.

Due to (or as a consequence of):

d.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Benjamin Avrarin, M.D.

29c. License number

D08381

29d. Date signed (Month, Day, Year)

July 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin Avrarin, M.D. 18111 Prince Philip Drive Olney, Maryland 20832

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

Benjamin G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24327

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harriet E. Fowkes

2. Date of Death

July 17, 1999

3. Time of Death

10:45 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

213-40-9650

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 24, 09

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges'

10c. City, Town or Location

Mt. Rainier

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3105 Perry Street

10f. Zip Code

20712

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

6

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Edward Crisp

18. Mother's Name (First, Middle, Maiden Surname)

Francis Wilson

19a. Informant's Name/Relationship (Type, Print)

Marilyn F. Stadler-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5605 Quincy Street, Hyattsville, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

7-21-99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

L. S. Johnson

22. Name and Address of Facility

Fort Lincoln Funeral Home

3401 Bladensburg Rd., Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5+ YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. M. Sparks

29c. License number

20391

29d. Date signed (Month, Day, Year)

July 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. J. M. Sparks, 6525 BELCREST RD, HYATTSVILLE, MD

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

J. M. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24328

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Elizabeth L. Franzmathes | | | | 2. Date of Death Month Day Year July 21 1999 | | 3. Time of Death 7:40 P.M. | |
| 4a. Facility Name (If not institution, give street and number) Carriage Hill - Bethesda | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| 5. Social Security Number 509-09-4592 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) July 20, 1907 | |
| 9. Birthplace (State or Foreign Country) Kansas | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Bethesda | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 5215 W. Cedar Lane | | 10f. Zip Code 20814 | | 10g. Citizen of What Country? U. S. A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) A. Fred Lutz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rose Mary Farley | | | |
| 19a. Informant's Name/Relationship (Type, Print) George Daigre - Trustee | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5550 Friendship Blvd. Chevy Chase, MD 20815 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Cemetery | | Date 7/26/99 | | 20c. Location - City or Town, State Beloit, Kansas | |
| 21. Signature of Funeral Service Licensee Thomas E. Hornbaker | | | | 22. Name and Address of Facility Joseph Gawler's Sons 5130 WI Ave. N. W. Washington, D.C. 20016 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Cardiac Arrest Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Approximate interval Between Onset and Death 20 Years Immediate | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asthma, Alzheimer's Type Dementia | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Irving Mizus, MD | | | | 29c. License number D 26571 | | 29d. Date signed (Month, Day, Year) July 23, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irving Mizus, M. D. 4930 Del Ray Ave. #301 Bethesda, MD 20814 | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | | | 32. Registrar's Signature B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24329

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|---|---|---|--|---------------------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Pedro Fuentes | | | | 2. Date of Death Month July Day 19 Year 99 | | | | 3. Time of Death 12:24 AM | |
| | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 460-99-7376 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 44 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 9, 1955 | | 9. Birthplace (State or Foreign Country) El Salvador | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 15 Manchester Place, #101 | | | | 10f. Zip Code 20901 | | 10g. Citizen of What Country? El Salvador | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: El Salvadoran | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer | | | | 16b. Kind of Business/Industry Printing Company | |
| | 17. Father's Name (First, Middle, Last) Pedro Vialos | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carman Fuentes | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Sandos I. Vasquez (friend) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Manchester Place, #101, Silver Spring, MD 20901 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Jardines del Recuerdo | | Date 7-28-99 | | 20c. Location - City or Town, State San Salvador, El Salvador | |
| | 21. Signature of Funeral Service Licensee Carola Del | | | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cryptococcal meningitis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death 3 weeks | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acquired Immunity Deficiency Syndrome | | | | | | | | | |
| State Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acquired Immunity Deficiency Syndrome | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) — | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred — | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) — | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) — | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier Rahul Gilotra | | 29c. License number D 32417 | | |
| 29d. Date signed (Month, Day, Year) July 19th, 1999 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAHUL GILOTRA 12016 GEORGIA AVENUE WHEATON MD 20902 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 | | | | 32. Registrar's Signature James B. Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24330

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--------------------------------|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rosalie Freeman | | | | 2. Date of Death Month Day Year JULY 14, 1999 | | 3. Time of Death 2245 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) MARYLAND ROUTE#322 (EASTON PARKWAY) | | | | 4b. City, Town, or Location of Death Easton | | 4c. County of Death TALBOT | | | |
| Funeral Director | 5. Social Security Number 220-32-1616 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 9, 1935 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Talbot | 10c. City, Town or Location Easton | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 10 Village Street Apt. 73 | | | 10f. Zip Code 21601 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Line Worker | | 16b. Kind of Business/Industry Manufacturing | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Raymond Miles | | | | 18. Mother's Name (First, Middle, Maiden Surname) Clara Bell Roberts | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Clarica E. Robinson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Village Street Apt. 73 Easton, MD. 21601 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Paradise Cemetery | | 20c. Location - City or Town, State 7/21/99 + rappe, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee Janelle C. Henry | | 22. Name and Address of Facility HENRY FUNERAL HOME P.A. 510 Washington St. Cambridge, MD. 21613 | | | | | | | |
| Physician /Medical Examiner | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE TRAUMAS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 7 14 99 | | 28b. Time of Injury 22:33P M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred PEDESTRIAN STRUCK BY CAR | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROADWAY | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) MD RT 322 TALBOT CO MD | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Maupie Michelle | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) JULY 15, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPSKY DUNN A. KOSIN 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24331

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES WILLIAM FITZHUGH

2. Date of Death

Month Day Year
July 17 1999

3. Time of Death

12:35 am

4a. Facility Name (If not Institution, give street and number)

Chesapeake Woods Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

215-20-0265

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 5 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2905 Central Road

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

carpenter

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

Enos Washington Fitzhugh

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Insley

19a. Informant's Name/Relationship (Type, Print)

Logan H. Fitzhugh - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2905 Central Rd., Cambridge MD 21613

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dorchester Memorial Park

Date

7-20-99

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home

700 Locust St. Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular Accident

4 years

c. Peripheral Vascular Disease

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ OOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Eugene J. Newman M.D. Physician

29c. License number

H51743

29d. Date signed (Month, Day, Year)

7/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene Newman D.O. 503 Byrn St Cambridge MD 21613

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24332

| | | | | | | | | | | | |
|--|---|--|--|---|--|--|---|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen M. Garrity | | | | 2. Date of Death Month Day Year July 19, 1999 | | | | 3. Time of Death 11:05pm | | |
| | 4a. Facility Name (If not institution, give street and number) Sligo Creek Nursing Center | | | | 4b. City, Town, or Location of Death Takoma Park | | | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 032-07-8118 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) July 10, 1918 | | 9. Birthplace (State or Foreign Country) Massachusetts | | |
| | Usual Residence of Decedent | | | | 10a. State Virginia | | | | 10b. County Fairfax | | 10c. City, Town or Location Annandale |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 4005 Estabrook Drive | | | | 10f. Zip Code 22003 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | | | 16b. Kind of Business/Industry Fashion/Retail | | | |
| 17. Father's Name (First, Middle, Last) James N. O'Shaughnessy | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Brogan | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Diane C. Garrity/ Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Estabrook Drive, Annandale, VA 22003 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven | | | | Date July 24 1999 | | 20c. Location - City or Town, State Silver Spring, MD | |
| 21. Signature of Funeral Service Licensee <i>James E. Dooley</i> | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, MD 20901 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. ACUTE ASPIRATION Due to (or as a consequence of): b. NEUROLOGIC OXYSTROIA Due to (or as a consequence of): c. DEMANTIA, ALZHEIMER'S TYPE Due to (or as a consequence of): d. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>MO. (ONE)</i> | | | | 29c. License number 015236 | | 29d. Date signed (Month, Day, Year) JUL 23, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL I. MARGOLIS, MD 1115 ROCKVILLE PIKE, ROCKVILLE, MD 20852 | | | | 31. Date filed (Month, Day, Year) JUL 23 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

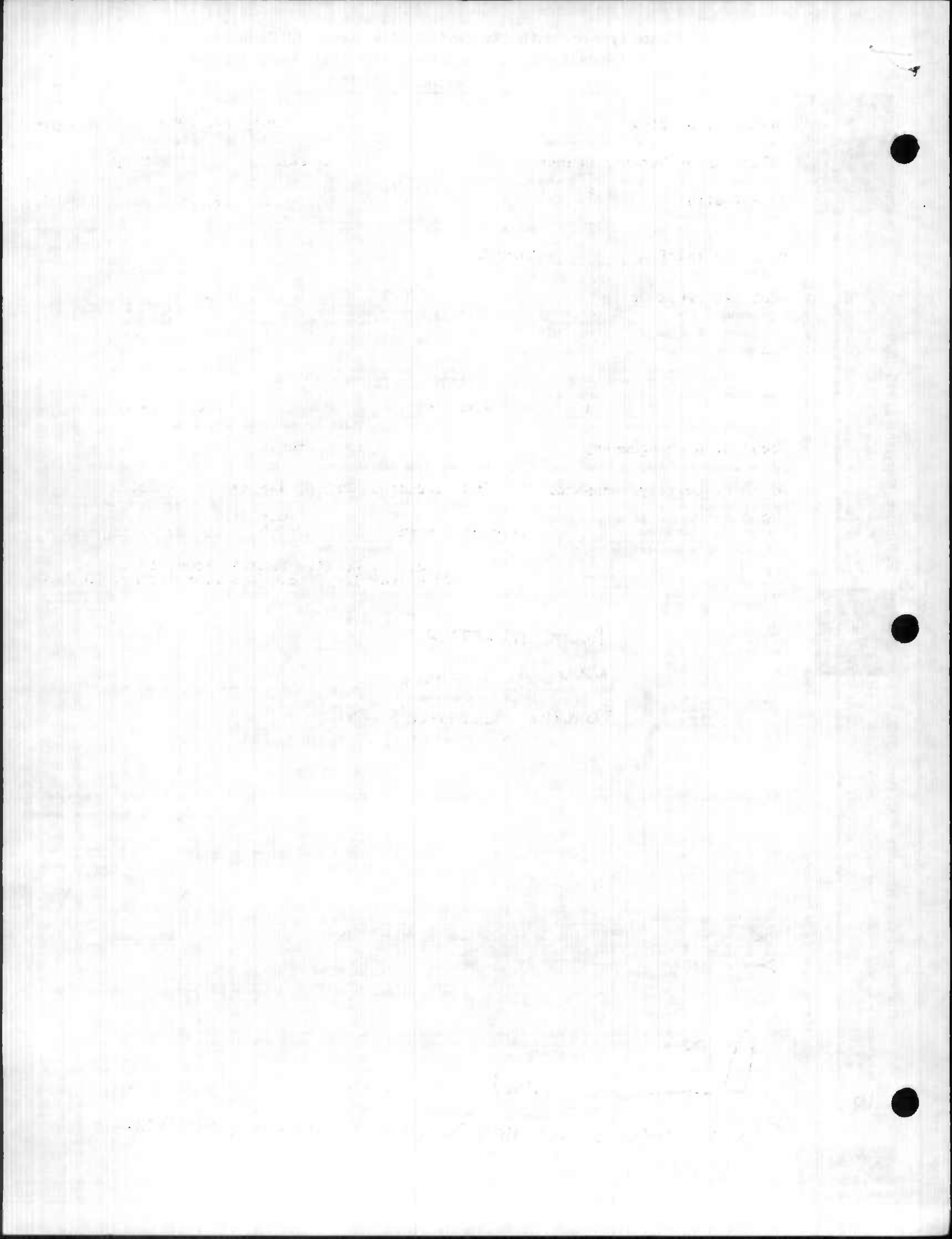
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 20B, 20C 7/19/99 CMH AACO HEALTH *Certificate of Death*

Reg. No.

99 24333

| | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) C. Marie Gent | | | | 2. Date of Death Month Day Year July 11, 1999 | | | | 3. Time of Death 6:08AM | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 059-18-3208 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 | | 8. Date of Birth (Month, Day, Year) Oct. 12, 1920 | | 9. Birthplace (State or Foreign Country) Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Edgewater | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 400 Londontown Road | | | | 10f. Zip Code 21037 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Home | | |
| 17. Father's Name (First, Middle, Last) Aleph H. Wood | | | | 18. Mother's Name (First, Middle, Maiden Surname) Beulah Drumheller | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles Gent/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Londontown Road Edgewater, Maryland 21037 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HILLCREST MEMORIAL GARDENS | | Date 7-14-99 | | 20c. Location - City or Town, State ANNAPOLIS, MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Resp Failure Dua to (or as a consequence of): b. Progressive Acute Myocardial Infarction Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Acute Stenosis | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number 003557 | | 29d. Date signed (Month, Day, Year) July 12, 1999 | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) ROBERT M. GREENFIELD M.D. 139 OLD SOLOMONS ISLAND ROAD ANNAPOLIS, MD. 21401 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24334

| | | | | | | | | |
|---|--|---|---|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Odessa W. Greene | | | | 2. Date of Death Month July Day 9 Year 1999 | | 3. Time of Death 12:10 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 803 Coxswain Way #101 | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 404-28-3640 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Apr. 3, 1925 | 9. Birthplace (State or Foreign Country) Kentucky |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Anne Arundel | 10c. City, Town or Location Annapolis | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 803 Coxswain Way #101 | | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Home | | |
| | 17. Father's Name (First, Middle, Last) Hiram Wooten | | | | 18. Mother's Name (First, Middle, Maiden Surname) Martha Napier | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Fred A. Greene, Jr./ Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 Coxswain Way #101 Annapolis, Maryland 21401 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem'l. Gardens | | Date 7-12-99 | 20c. Location - City or Town, State Davidsonville, MD | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 | | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Respiratory Failure Due to (or as a consequence of): b. Idiopathic Interstitial Pulmonary Fibrosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D12015 | | 29d. Date signed (Month, Day, Year) 7-9-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Louis Steinberg MD 6492 Landover Rd, Landover, MD 20785 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 12 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24335

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alexis Victoria Garcia-Jimenez

2. Date of Death

Month Day Year
July 6, 1999

3. Time of Death

12:34 A.M.

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

N/A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

0

Yrs.

If Under 1 Year

Months Days

3

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 3, 1999

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6125 Gray Wolf Court

10f. Zip Code

20603

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☒ Yes 2 ☐ No Specify: Ecuadorean

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

John David Jimenez

18. Mother's Name (First, Middle, Maiden Surname)

Renee Elizabeth Garcia

19a. Informant's Name/Relationship (Type, Print)

John D. Jimenez/ Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6125 Gray Wolf Court Waldorf, Maryland 20603

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Mem'l. Gardens

Date

7-9-99

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Extreme Prematurity

Pulmonary Hemorrhage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Misbah A. Qureshi MD

29c. License number

D0051310

29d. Date signed (Month, Day, Year)

July 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Misbah A. Qureshi, M.D. 22 S. Greene Street Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUL 09 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

JUL 26 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24336

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|---------------------------|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ruby Fuller Garner | | | | 2. Date of Death Month Day Year July 21, 1999 | | | | 3. Time of Death 6:10 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Rehabilitation & Nursing Center | | | | 4b. City, Town, or Location of Death Burtonsville | | | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 215-50-1752 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) April 30, 1904 | | 9. Birthplace (State or Foreign Country) Illinois | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 2201 Colston Drive, #404 | | | | 10f. Zip Code 20910 | | 10g. Citizen of What Country? United States | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) John P. Fuller | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bessie Lackey | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Bettie G. Peake (daughter) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Calgary Avenue, Kensington, Maryland 20895 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park | | Date 7-23-99 | | 20c. Location - City or Town, State Rockville, Maryland | | | | |
| 21. Signature of Funeral Service Licensee Carol A. DeLeon | | | | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death 1 month | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Paul Armstrong | | | | | 29c. License number D43237 | | | 29d. Date signed (Month, Day, Year) July 22, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong, M.D., 14201 Laurel Park Drive, #102, Laurel, Maryland 20707 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | | 32. Registrar's Signature B. Spaw | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24337

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pranee Garnier

2. Date of Death

Month Day Year
July 17, 1999

3. Time of Death

2:17 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3302 Tidewater Court

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

577-76-5539

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
May 24, 1943

9. Birthplace (State or Foreign Country)

Thailand

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3302 Tidewater Court

10f. Zip Code

20832

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Thai

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

clerk

16b. Kind of Business/Industry

copy shop

17. Father's Name (First, Middle, Last)

Pradit Sukhum

18. Mother's Name (First, Middle, Maiden Surname)

Rabieb (unavailable)

19a. Informant's Name/Relationship (Type, Print)

Frank K. Garnier (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3302 Tidewater Court, Olney, Maryland 20832

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

7-19-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Delm

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC CERVICAL CARCINOMA

Due to (or as a consequence of):

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Kaplan

29c. License number

D35635

29d. Date signed (Month, Day, Year)

July 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan, M.D., 18111 Prince Philip Drive, #327, Olney, Maryland 20832-1513

State
Registrar

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

Jenna B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24338**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth M. Goss

2. Date of Death
Month Day Year
July 17, 1999

3. Time of Death
6:25 am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

215-12-3355

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 16, 1923

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9700 Fernwood Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Ewing Queen

18. Mother's Name (First, Middle, Maiden Surname)

Mary Kent

19a. Informant's Name/Relationship (Type, Print)

Earle D. Goss, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21900 Slidell Road Boyds, Maryland 20834

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

[Signature] M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LYMPHOMA

Due to (or as a consequence of):

b. INDOLENT LYMPHOMA (Non-Hodgkins)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

3 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytopenia

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] E.P. Libre MD

29c. License number

D09470

29d. Date signed (Month, Day, Year)

July 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EUGENE P. LIBRE M.D.

10400 CONNECTICUT AVE
KENSINGTON, MD. 20845

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

[Signature] B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24339

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|----------------------------------|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John M. Grahek | | | | 2. Date of Death Month July Day 17 Year 1999 | | | | 3. Time of Death 18:00 | |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 380-16-0182 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 80 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) Sept 30, 1918 | | 9. Birthplace (State or Foreign Country) Michigan | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Potomac | |
| Usual Residence of Decedent | | | | | | | | | | |
| 10d. Inside City Limits 1 Yes 2 No | | | | | | | | | | |
| 10e. Street and Number 11200 River Road | | | | | | | | | | |
| 10f. Zip Code 20854-1533 | | | | | | | | | | |
| 10g. Citizen of What Country? United States | | | | | | | | | | |
| 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced | | | | | | | | | | |
| 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | | | | | | | | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) College (14 or 5+) | | | | | | | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Handyman | | | | | | | | | | |
| 16b. Kind of Business/Industry Construction | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) John Grahek | | | | | | | | | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Ann Ghena | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Verna G. Mize/Sister | | | | | | | | | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11200 River Road, Potomac, Maryland 20854-1533 | | | | | | | | | | |
| 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | | | | | | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) July 20, 1999 Montgomery Crematorium, Inc. | | | | | | | | | | |
| 20c. Location - City or Town, State Bethesda, Maryland | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Robert A. Pumfrey M00803 | | | | | | | | | | |
| 22. Name and Address of Facility Robert A. Pumfrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501 | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Due to (or as a consequence of): b. Gastrointestinal bleed Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 Yes 2 X No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bilateral above knee amputations | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 X No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | | | | | |
| 28b. Time of Injury M | | | | | | | | | | |
| 28c. Injury at Work? 1 Yes 2 No | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Nancy P. Lawless | | | | | | | | | | |
| 29c. License number D 43517 | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) July 17, 1999 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nancy P. Lawless, M.D. 12515 Feldon Street, Silver Spring, Maryland 20906 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | | | | | | | | | |
| 32. Registrar's Signature Denise B. Sparks | | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24340

| | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard R. Hetrick | | | | | 2. Date of Death Month Day Year July 18, 1999 | | 3. Time of Death 5:35 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 5513 CARVEL STREET | | | | | 4b. City, Town, or Location of Death CHURCHTON | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 579-42-9913 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) Sep. 11, 1933 | | 9. Birthplace (State or Foreign Country) Washington, DC | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Churchton | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10a. Street and Number 5513 Carvel Street | | | | 10f. Zip Code 20733 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th | | College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer | | | 16b. Kind of Business/Industry Maintenance | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Mark Henry Hetrick | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie Naomi Yorty | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Lynn H. Healey/ Daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7925 Fairfax Road Alexandria, Virginia 22308 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Grantville Cemetery | | Date 7-22-99 | | 20c. Location - City or Town, State Grantville, PA | | | |
| | 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): b. Cardiac Ischemia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 11 minutes 14 yrs | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier | | | | | 29c. License number D38563 | | 29d. Date signed (Month, Day, Year) July 19, 1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne Barbaum 134 Owensville Rd, West River MD | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 20 1999 | | | | | 32. Registrar's Signature | | | | |

ORIGINAL

[Handwritten signature]

JUL 5 1966

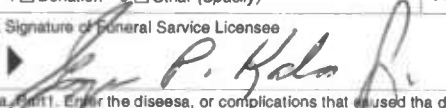
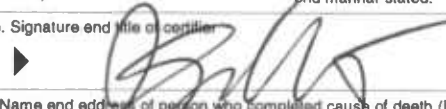
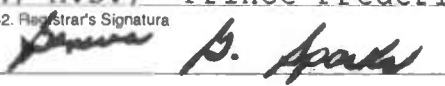
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24341

| | | | | | | | | |
|---|--|--|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOSEPH P. HOUSTON | | | | 2. Date of Death Month Day Year JULY 13, 1999 | | 3. Time of Death 13:20 | |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 218-18-1717 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 18, 1920 | |
| | 9. Birthplace (State or Foreign Country) Olyphant, PA. | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Lothian | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 112 5th St. | | | | 10f. Zip Code 20711 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lithographer | | 16b. Kind of Business/Industry Newspaper | |
| | 17. Father's Name (First, Middle, Last) Aloysius S. Houston | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen McKenna | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Jean E. Houston/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veteran's Cem. 7/16/99 | | 20c. Location - City or Town, State Cheltenham, MD. | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, MD 21037 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. Post obstructive pneumonia</p> <p>b. Metastatic lung Cancer</p> <p>c. tobacco addiction</p> <p>d.</p> </div> </div> | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D59449 | | 29d. Date signed (Month, Day, Year) 7/14/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David Gallatin, M.D., Prince Frederick, MD. 20678 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

JUL 8 1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24342

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

REDA B. HAMILTON

2. Date of Death

7 17 99

3. Time of Death

100 AM

4a. Facility Name (If not institution, give street and number)

Prince Georges' Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges'

5. Social Security Number

214-30-2370

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

April 18, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges'

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3809 Largo Road

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lewis Cabbage

18. Mother's Name (First, Middle, Maiden Surname)

Lucy F. Pence

19a. Informant's Name/Relationship (Type, Print)

Judy F. Hamilton-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5801 Woodyard Road, Upper Marlboro, Maryland 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cemetery 7-21-99 Brentwood, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Fort Lincoln Funeral Home
3401 Bladensburg Rd., Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC RESPIRATORY FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile dementia with Psychotic features

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

022780

29d. Date signed (Month, Day, Year)

7/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter M Schissler MD 7500 Greenway Ctr Dr. Greenbelt Md 20770

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

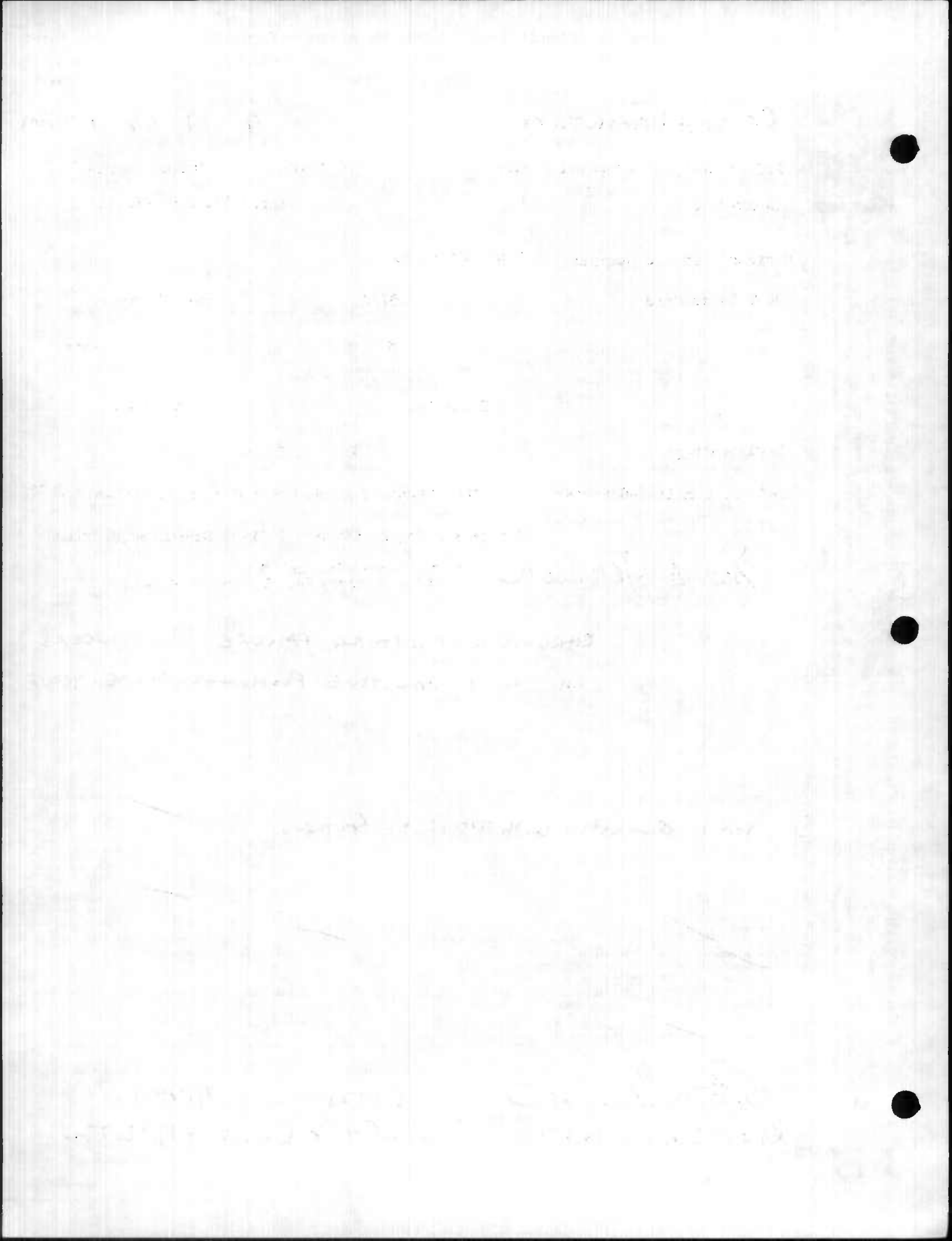
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24343

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WARD

--

HARRIS

2. Date of Death

Month Day Year
JULY 19 1999

3. Time of Death

9:25 AM

4a. Facility Name (If not institution, give street and number)

BROOKE GROVE NURSING HOME

4b. City, Town, or Location of Death

SANDY SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

225 05 6355

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 24, 1911

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

GAITHERSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24211 LAYTONSVILLE ROAD

10f. Zip Code

20882

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LANDSCAPER

16b. Kind of Business/Industry

LANDSCAPING

17. Father's Name (First, Middle, Last)

GEORGE HARRIS

18. Mother's Name (First, Middle, Maiden Surname)

MINERVA HARGRAVES

19a. Informant's Name/Relationship (Type, Print)

JOANN McCORMICK, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17821 BUEHLER ROAD, #106, OLNEY, MD. 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LAYTONSVILLE CEMETERY

Date

7/22/99

20c. Location - City or Town, State

LAYTONSVILLE, MD.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME

P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RENAL FAILURE

Approximate Interval Between Onset and Death

3 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
CEREBROVASCULAR ACCIDENT

30 YEARS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carolyn Baier MD

29c. License number

D34386

29d. Date signed (Month, Day, Year)

JULY 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carolyn Baier MD 1396 Piccard Dr. Rockville, MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24344

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth

A.

Harrison

2. Date of Death

Month Day Year
July 20, 1999

3. Time of Death

1:20 PM

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

1506 Highland Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

076-09-1359

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 4, 1905

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1506 Highland Drive

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Dining Room Worker

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

John M. Harrison

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Cronin

19a. Informant's Name/Relationship (Type, Print)

Clare Dell'Olio (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1506 Highland Drive, Silver Spring, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Mary's Cemetery

Date

7/23/99

20c. Location - City or Town, State

Cortland, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.
5517 Vine Street, Alexandria, VA 2231023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 Days

b. Dementia

Due to (or as a consequence of):

Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Vasomotor Instability

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ernest S. Oser, M.D. 10301 Georgia Avenue, Silver Spring, MD 20902

State
Registrar

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

Ernest S. Oser

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24345

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|--|---|---|--|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ruth E. Hausafus | | | | | | 2. Date of Death Month Day Year July 15, 1999 | | | 3. Time of Death 0415 | | | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | | | 4b. City, Town, or Location of Death ROCKVILLE | | | 4c. County of Death MONTGOMERY | | | |
| Funeral Director | 5. Social Security Number 577-09-4351 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) Dec. 21, 1919 | 9. Birthplace (State or Foreign Country) Washington, DC | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 504 Nelson Street | | | | 10f. Zip Code 20850 | | | | 10g. Citizen of What Country? United States | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | | 16b. Kind of Business/Industry U.S. Government | | | | | |
| 17. Father's Name (First, Middle, Last) Sammuel Stockton Blackman | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ella Dean | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert C. Hausafus/Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7108 Aquia Drive, Stafford, Virginia 22554 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rockville Cemetery | | | | Date July 19, 1999 | | 20c. Location - City or Town, State Rockville, Maryland | | | |
| 21. Signature of Funeral Service Licensee David E. Perry M00803 | | | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) e. PNEUMONIA | | | | | | | | | | | | 24 hours | |
| Due to (or as a consequence of): | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. EMPHYSEMA | | | | | | | | | | | | 5 years | |
| Due to (or as a consequence of): | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Carl I. Schoenberg MD | | | | | | 29c. License number D 26540 | | 29d. Date signed (Month, Day, Year) JULY 15 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Carl I. Schoenberg 16220 Fendrich Rd. Gaithersburg MD | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24346

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|---|---|---|--|--------------------------|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harold Helfer | | | | 2. Date of Death Month Day Year July 18, 1999 | | | | 3. Time of Death 10:35AM | | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Spring | | | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 416-10-9722 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 19, 14 | | 9. Birthplace (State or Foreign Country) New York | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 8505 Springvale Rd. #45 | | | | 10f. Zip Code 20910 | | | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Writer/Reporter | | | | 16b. Kind of Business/Industry Private | | | |
| 17. Father's Name (First, Middle, Last) Sam Helfer | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rose Goldberg | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) H.Mark Helfer/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Franklin St. Middletown, MD. 21769 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial | | Date 7/21 | | 20c. Location - City or Town, State Olney, MD. | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Takoma Funeral Home. 254 Carroll St. NW Washington, DC. 20012 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate interval Between Onset and Death Years Years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Heart Disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  Dr. Howard G. W. Brown | | | | 29c. License number 1008188 | | | | 29d. Date signed (Month, Day, Year) 7-18-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUGO G. GRAZIANI JR. 717 NEWHOLD DR. SILVER SPRING MD 20910 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 | | 32. Registrar's Signature  | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24347

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Griffith Holland

2. Date of Death

Month Day Year
July 17, 1999

3. Time of Death

03:00AM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

218-34-5646

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 13, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1307 Greenmont Drive

10f. Zip Code

20601

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

President

16b. Kind of Business/Industry

Holland Construction

17. Father's Name (First, Middle, Last)

Edward Holland

18. Mother's Name (First, Middle, Maiden Surname)

Mary Brooks

19a. Informant's Name/Relationship (Type, Print)

Edward Holland III /son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1307 Greenmont Dr., Waldorf, MD 20601

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Washington National

Date

7/23/99

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Ave. N.W., Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

unknown

b. Respiratory insufficiency

Due to (or as a consequence of):

unknown

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia, Stroke, Seizure disorder

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24e. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury et
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Medical Examiner12. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. Signature and title of certifier

29c. License number

D50454

29d. Date signed (Month, Day, Year)

July 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARASTOO YAZDANI, M.D., VA Maryland Health Care System, Perry Point, MD 21902

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

State
RegistrarNAME KNOWN TO PHYSICIAN: EDWARD G. HOLLAND
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24348
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KENNETH W. HOWES SR.

2. Date of Death

JULY 14 1999

3. Time of Death

6:15 PM

4a. Facility Name (If not institution, give street and number)

18702 Curry Powder Lane

4b. City, Town, or Location of Death

Germantown

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

219-48-9596

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov. 22 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18702 Curry Powder Lane

10f. Zip Code

20874

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1972-1973

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Glazier

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Elias Woodrow Howes

18. Mother's Name (First, Middle, Maiden Summa)

Marjorie Virginia Oden

19a. Informant's Name/Relationship (Type, Print)

Darlene Howes/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18702 Curry Powder Lane, Germantown, Md. 20874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Carmel Cemetery

Date

7/17/99

20c. Location - City or Town, State

Sunshine, Maryland

21. Signature of Funeral Service Licensee

Roy W. Bauer

22. Name and Address of Facility

Muriel H. Barber Funeral Home
P. O. Box 5038 Laytonsville, Maryland 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CENTRAL NERVOUS SYSTEM CARCINOMATOSIS

2 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MULTIPLE MYELOMA

1 YEAR

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Roy W. Bauer MD

29c. License number

D 45274

29d. Date signed (Month, Day, Year)

July 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cho Maung, M.D. 10810 Connecticut Ave., Kensington, Maryland 20895

State
Registrar

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

Jennifer B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 25a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 + 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24349

| | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|---|--|--------------------------|--|--|---|---|----|------------|---|----|---|----|----------------------------------|----|----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE EDWARD HUNTER | | | | 2. Date of Death Month Day Year JULY 14 1999 | | | | 3. Time of Death 16:03 | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death ROCKVILLE | | | | 4c. County of Death MONTGOMERY | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 220-38-2629 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 18, 1941 | | 9. Birthplace (State or Foreign Country) Washington D.C. | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Sandy Spring | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number 18009 Branchwood Lane | | | | 10f. Zip Code 20860 | | | | 10g. Citizen of What Country? United States | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | | 16b. Kind of Business/Industry Septic Service | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Edward Hunter | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Beulah Fagan | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Virginia Hunter / Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18009 Branchwood Lane, Sandy Spring, Md. 20860 | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 7/16/99 | | 20c. Location - City or Town, State Alexandria, Virginia | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038 Laytonsville, Maryland 20882 | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Arrhythmia</td> <td rowspan="4"> Approximate Interval Between Onset and Death 17 minutes Years </td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): Coronary Artery Disease</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Arrhythmia | Approximate Interval Between Onset and Death 17 minutes Years | b. | Due to (or as a consequence of): Coronary Artery Disease | c. | Due to (or as a consequence of): | d. | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Arrhythmia | Approximate Interval Between Onset and Death 17 minutes Years | | | | | | | | | | | | | | | | |
| | b. | Due to (or as a consequence of): Coronary Artery Disease | | | | | | | | | | | | | | | | | |
| | c. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| | d. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| | | | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | 29c. License number 053261 | | | 29d. Date signed (Month, Day, Year) July 14, 1999 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Dooley, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 19 1999 | | | | 32. Registrar's Signature  | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24350

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles Clifton Holden | | | | 2. Date of Death Month Day Year July 8, 1999 | | | | 3. Time of Death 5:55 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Magnolia Hall Nursing Center | | | | 4b. City, Town, or Location of Death Chestertown | | | | 4c. County of Death Kent | |
| Funeral Director | 5. Social Security Number 217-36-0203 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) July 17, 1907 | | 9. Birthplace (State or Foreign Country) Church Hill, MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Queen Anne's | | 10c. City, Town or Location Chestertown | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 805 Bowers Road | | | | 10f. Zip Code 21620 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | | 16b. Kind of Business/Industry Agriculture | | |
| | 17. Father's Name (First, Middle, Last) Thomas Wesley Holden | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lydia Walraven | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Louise E. Holden/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Bowers Road, Chestertown, Maryland 21620 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Church Hill Cemetery | | Date 7/10/99 | | 20c. Location - City or Town, State Church Hill, Maryland | | | |
| | 21. Signature of Funeral Service Licenses  | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic heart disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 23c. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic bronchitis | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | |
| State Registrar | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier  | | | | 29c. License number D16488 | | 29d. Date signed (Month, Day, Year) 7/8/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D Benjamin, MD, Chestertown, MD 21620 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 09 1999 | | | | | | | | | | |
| 32. Registrar's Signature  | | | | | | | | | | |

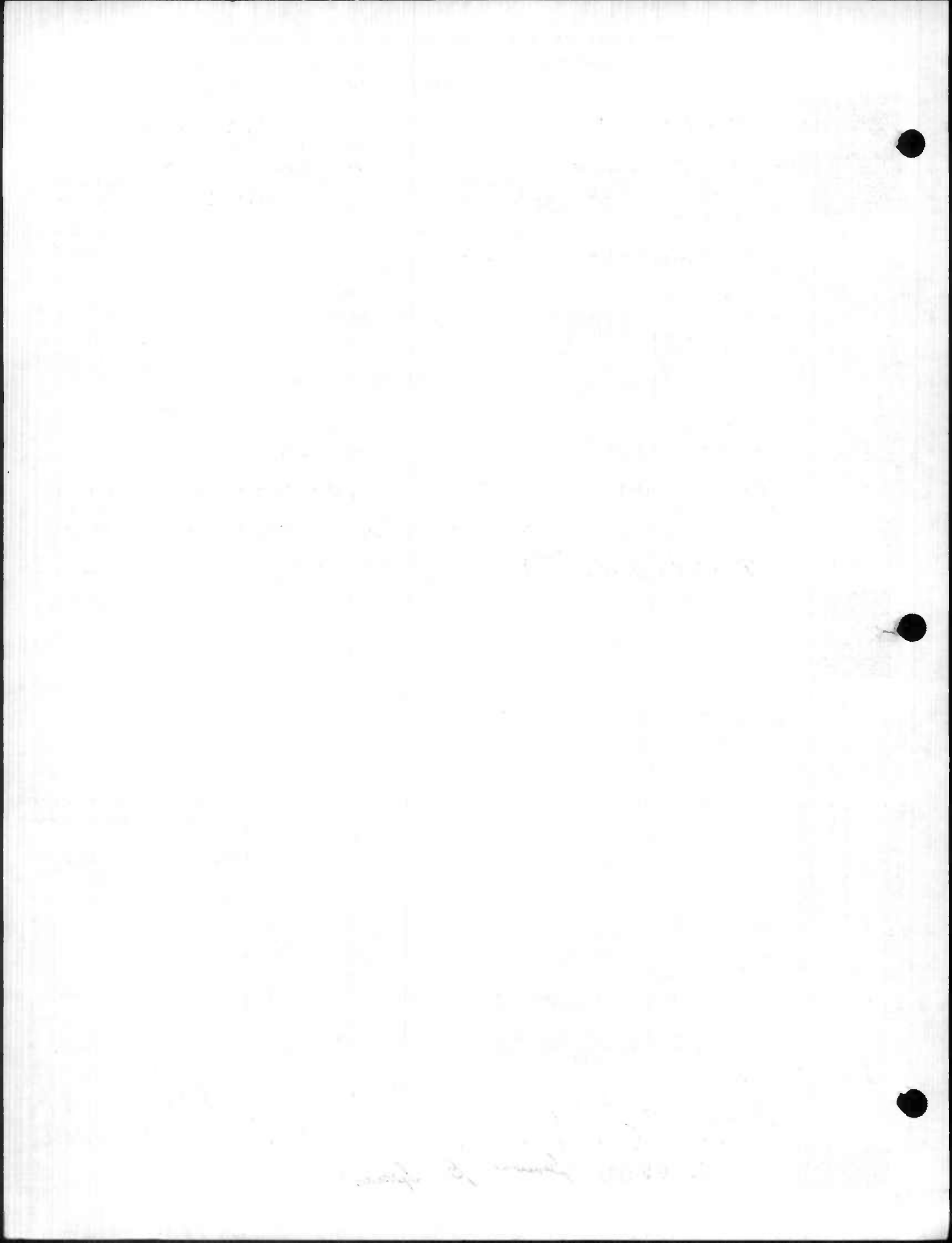
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



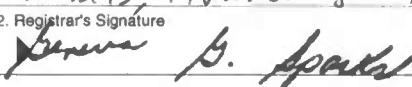
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24351

| | | | | | | | | |
|---|--|--|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Jane Haniffee | | | | 2. Date of Death Month July Day 12 Year 1999 | | 3. Time of Death 1348 | |
| | 4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital | | | | 4b. City, Town, or Location of Death Chestertown | | 4c. County of Death Kent | |
| Funeral Director | 5. Social Security Number 218-20-3440 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) August 5, 1926 | |
| | 9. Birthplace (State or Foreign Country) Cecilton, Maryland | | 10a. State Maryland | | 10b. County Kent | | 10c. City, Town or Location Chestertown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 509 Cannon Street | | 10f. Zip Code 21620 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk/Asst. Manager | | 16b. Kind of Business/Industry Sales | | | |
| | 17. Father's Name (First, Middle, Last) James Patrick Haniffee | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lydia Newnam | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Allan T. Haniffee/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Pine Street, Chestertown, MD 21620 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC 7/17/99 | | 20c. Location - City or Town, State Chester, Maryland | | | |
| | 21. Signature of Funeral Service Licenses  | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic pulmonary Arterist Due to (or as a consequence of): b. Pneumatic Canceroma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcohol Abuse. | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) none | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 823889 | | 29d. Date signed (Month, Day, Year) 7/13/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Annas MC 2115 948 Washington Ave, Chestertown Md 21620 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | | | 32. Registrar's Signature  | | | | |

[Faint handwritten signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24352

SHAH DINESH DR CENTER MEDICAL VIRGINIA WEST 0839 HRS TIME OF DEATH 1011 SS # 216 18 1011 HARE, ROBERT

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.


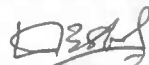
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) ROBERT RAYMOND HARE | | | | 2. Date of Death Month 07 Day 29 Year 99 | | | | 3. Time of Death 8:39 AM | | | | |
| 4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | | | 4c. County of Death ALLEGANY | | | | |
| 5. Social Security Number 216-18-1011 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 03/06/25 | | 9. Birthplace (State or Foreign Country) CUMBERLAND, MD | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State MD | | 10b. County ALLEGANY | | 10c. City, Town or Location CUMBERLAND | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 10e. Street and Number 224 ARCH STREET | | | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? US | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STATE POLICE OFFICER | | | 16b. Kind of Business/Industry POLICE DEPARTMENT | | | | | |
| 17. Father's Name (First, Middle, Last) JOHN WILSON HARE | | | | 18. Mother's Name (First, Middle, Maiden Surname) EMMA JANE BARGER | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) WVU HGR | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 9128, MORGANTOWN, WV 26506 | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OMEGA CREMATORY | | Date 7/30/99 | | 20c. Location - City or Town, State MORGANTOWN, WV | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility WVU HGR P.O. BOX 9128, MORGANTOWN, WV 26506 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR FIBRILLATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | Approximate Interval Between Onset and Death 1 HOUR | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS TYPE 1. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  MD | | | | | | | 29c. License number D-23334 | | 29d. Date signed (Month, Day, Year) JULY 29th 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINESH SHAH, M.D. 205 JOHNSON HTS MED BLDG, CUMBERLAND, MD 21502. | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature  | | | | | | | | | | |

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24353

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francis William Hill

2. Date of Death

Month Day Year
July 23 1999

3. Time of Death

11:45PM

4a. Facility Name (If not institution, give street and number)

Shore Nursing & Rehabilitation Center

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

077-16-0281

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 12 1911

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Md.

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1030 Heritage Court

10f. Zip Code

21629

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Purchasing agent

16b. Kind of Business/Industry

Chemical Company

17. Father's Name (First, Middle, Last)

Arthur Francis Hill

18. Mother's Name (First, Middle, Maiden Surname)

Susie Eileen Wheeler

19a. Informant's Name/Relationship (Type, Print)

Edith Smith Hill/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1030 North Heritage Court, Denton, Md. 21629

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capital Crematory

Date

7/25/99

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee

Kandolph P. Moore

22. Name and Address of Facility

MOORE FUNERAL HOME, P.A.
125-2nd St. Denton, Md 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular disease

Due to (or as a consequence of):

b. Atrial fibrillation

Due to (or as a consequence of):

c. Parkinson's disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 weeks

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jorge A Brego MD

29c. License number

D0051132

29d. Date signed (Month, Day, Year)

7-24-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JORGE ABREGO, MEDICAL CNTR. DAFFIN LANE, DENTON MD 21629

31. Date filed (Month, Day, Year)

JUL 27 1999

32. Registrar's Signature

Benita S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1968 JUL 2 10 10 AM

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[illegible text block]

1968 JUL 2 10 10 AM

99 24354

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edna Louise Holland | | | | 2. DATE OF DEATH MONTH DAY YEAR July 24 1999 | | 3. TIME OF DEATH 12:45AM | |
| 4. SOCIAL SECURITY NUMBER 256-74-2328 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 11, 1913 | |
| 9a. FACILITY NAME (If not institution, give street and number) 9333 Double Hills Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Denton | | 9c. COUNTY OF DEATH Caroline | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Caroline | | 10c. CITY, TOWN OR LOCATION Denton | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9333 Double Hills Road | | | | 10f. ZIP CODE 21629 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 HS Grad. | | College (1-4 or 5+) 3 1/2 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse | | 16b. KIND OF BUSINESS/INDUSTRY Medical | |
| 17. FATHER'S NAME (First, Middle, Last) William Lee DeFord | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Edna Mezick | | | |
| 19a. INFORMANT'S NAME (Type/Print) Phyllis Smith | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 9333 Double Hills Road, Denton, Maryland 21629 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Blakely Cemetery | | DATE 7/30 | | 20c. LOCATION — City or Town, State Blakely, Georgia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles J. Moore</i> | | 22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. 21629 12 South Second Street, Denton, Maryland | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Metastatic lung cancer > 4-30-97 DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Adenocarcinoma of the lung > 4-30-97 DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pul. emphysema | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Robert W. Trever, M.D. | | | | 29c. LICENSE NUMBER D10938 | | 29d. DATE SIGNED (Month, Day, Year) July 26, 1999 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT W. TREVER M.D. 1696 OCEANVIEW AVE EASTON MD 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24355

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Martha I. Johnson

2. Date of Death

July 12

Day

1999

Year

3. Time of Death

10:05 PM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

204-10-6726

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 17, 1913

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

PA

10b. County

Mercer

10c. City, Town or Location

Sharon

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

124 Wangler Avenue

10f. Zip Code

16146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Charles Ingalls

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Mann Stoop

19a. Informant's Name/Relationship (Type, Print)

Charles F. Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13534 Paradise Church Rd. Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Memorial Park 7/16/99

Date

20c. Location - City or Town, State

Hermitage, PA

21. Signature of Funeral Service Licensee

J. W. Gore

22. Name and Address of Facility

Sample-O'Donnell Funeral Home, Inc.
555 East State Street Sharon, PA

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Acute Renal Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Ruptured Abdominal Aortic Aneurysm

Due to (or as a consequence of):

1 week

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Postoperative Congestive Heart Failure

and myocardial Infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Karl P. Ruggie

29c. License number

038764

29d. Date signed (Month, Day, Year)

7/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karl P. Ruggie, MD 1110 Med. J Campus Rd Suite 100 Hagerstown MD 21742

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Johnson, Martha I. 7/16/99
Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24356

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Selda Maria Jensen

2. Date of Death

Month Day Year
July 11 1999

3. Time of Death

1:43am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

417-24-3747

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
May 14 1923

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

na

10b. County

na

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4201 Butterworth Place

10f. Zip Code

20016

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dental Assistant

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Rueben Faulkner

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Kelly

19a. Informant's Name/Relationship (Type, Print)

Jeri Jensen-Moran daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4824 Park Ave., Bethesda, Md. 20816

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

National Crematory

Date

7/17/99

20c. Location - City or Town, State

Falls Church, Va.

21. Signature of Funeral Service Licensee

Thomas E. Hombaker

22. Name and Address of Facility

Joseph Gawler's Sons 5130 Wisconsin Ave. N.W.
Washington, D.C. 2001623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Severe Emphysema
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Gastrointestinal Bleeding

23b. Did tobacco use contribute to the cause of death?

☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

D. Scott Cohen, MD

29c. License number

Md. 42051

29d. Date signed (Month, Day, Year)

July 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Scott Cohen, MD 5454 Wisconsin Ave. #1125 Chevy Chase, Md. 20815

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

25

1972

[Handwritten signature]

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24357
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John J. Jocus | | | | 2. Date of Death Month Day Year July 17 1999 | | | | 3. Time of Death 5:50 AM | |
| | 4a. Facility Name (If not institution, give street and number) Genesis Eldercare - Spa Creek | | | | 4b. City, Town, or Location of Death Annapolis | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 220-16-8221 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 27, 1909 | | 9. Birthplace (State or Foreign Country) Rhode Island | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 670 Americana Drive Apt. 21 | | | | 10f. Zip Code 21403 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1928 - 1934 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Service | | | | 16b. Kind of Business/Industry U.S. Navy | |
| | 17. Father's Name (First, Middle, Last) Stanley Jocus | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Jervorawska | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Hazel Jocus / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 670 Americana Dr. Apt. 21 Annapolis, MD 21403 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Gardens | | 20c. Date 7/20/99 | | 20d. Location - City or Town, State Annapolis, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Brian Powell | | | | 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardio pulmonary arrest Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Jeffrey C. Schmidlein MD 29c. License number 030741 29d. Date signed (Month, Day, Year) 7 17 99 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey C. Schmidlein, M.D. 844 Ritchie Hwy. Suite 206 Severna Park, Md 21146 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 32. Registrar's Signature B. Sparks | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24358

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELEND L. JONES

2. Date of Death

JULY 8 1999

3. Time of Death

2112

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

040-28-4716

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

FEB. 8 1934

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

CROFTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1455 HARWELL AVENUE

10f. Zip Code

21114

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12thCollege (1-4 or 5+)
4 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

PRINCE GEORGE
PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

BENJAMIN LONDON

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE ISOM

19a. Informant's Name/Relationship (Type, Print)

EMERSON JONES (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1455 HARWELL AVE. CROFTON, MARYLAND 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS

Date

7/14/99

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Harry D. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BRAINSTEM CEREBROVASCULAR ACCIDENT

Approximate Interval Between Onset and Death

48 hrs.

Due to (or as a consequence of):

CENTRAL NERVOUS SYSTEM VASCULITIS

2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

POLYMYOSITIS

HYPERTENSION

HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

N/A

28d. Describe how injury occurred

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Larry W. Blum

29c. License number

D37246

29d. Date signed (Month, Day, Year)

July 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 FORBES ST. #302 ANNAPOLIS, MD. 21401

Larry W. Blum MD

31. Date filed (Month, Day, Year)

JUL 13 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-0000.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24359

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Francis L Jones | | | | 2. Date of Death Month 7 Day 9 Year 99 | | 3. Time of Death 1939 | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 220-38-7819 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 4, 1943 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 34 Oak Court | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Technician | | 16b. Kind of Business/Industry TV Repair | | | | |
| 17. Father's Name (First, Middle, Last) George C. Jones, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Charlotte E. Tydings | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Audrey L. Sheets / Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Hill Street Annapolis, MD 21401 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cem. | | Date 7-13-99 | | 20c. Location - City or Town, State Annapolis, MD. | | |
| 21. Signature of Funeral Service Licensee E. Brian Paul | | | | 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St Annap., Md 21401 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertension Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death 10 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier W. A. Muls | | 29c. License number 05-181 | | 29d. Date signed (Month, Day, Year) 7 10 99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1833 A. Forest Drive Annapolis, MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 12 1999 | | 32. Registrar's Signature P. A. [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

121000 000000 000000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24360

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EUSEBIA SILVA RIVERA JONES

2. Date of Death

Month Day Year
July 15, 1999

3. Time of Death

8:35 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-24-3583

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
FEB. 10, 1909

9. Birthplace (State or Foreign Country)

PUERTO RICO

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12325 NEW HAMPSHIRE AVE.

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:

PUERTO RICAN

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

UNK.

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

SILVA

18. Mother's Name (First, Middle, Maiden Surname)

ESTRADA

19a. Informant's Name/Relationship (Type, Print)

JOHN A. RIVERA/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12805 WEISS ST., ROCKVILLE, MD. 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

7/20/99

20c. Location - City or Town, State

BRENTWOOD, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

M00091

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Anoxic Encephalopathy

Due to (or as a consequence of):

b. Aspiration Pneumonia

Due to (or as a consequence of):

c. Seizure Disorder

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Renal Insufficiency; Anemia,

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D51083

29d. Date signed (Month, Day, Year)

July 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yisa O. Yussuf, MD, 6712 Village Park Drive, Greenbelt, MD 20770

State

Registrar

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1945

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #18, 7/22/99, T.M. Kent Co.

State of Maryland / Department of Health and Mental Hygiene

99 24361

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|---|---|--------------------------|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ODETTE ANNETTE JONES | | | | 2. Date of Death Month Day Year JULY 17 1999 | | | | 3. Time of Death 2050 | |
| | 4a. Facility Name (If not institution, give street and number) KENT & QUEEN ANNE'S HOSPITAL | | | | 4b. City, Town, or Location of Death CHESTERTOWN | | | | 4c. County of Death KENT | |
| Funeral Director | 5. Social Security Number 242-86-6936 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 46 Yrs. | | 8. Date of Birth (Month, Day, Year) October 29, 1952 | | 9. Birthplace (State or Foreign Country) Wisconsin | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Queen Anne's | | 10c. City, Town or Location Millington | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 200 Squires Lane | | | | 10f. Zip Code 21658 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own home | | |
| 17. Father's Name (First, Middle, Last) Frank Gillin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Roseileen Alder - Rosaline Alder - | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Pierson C. Jones, Jr./Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Squires Lane, Millington, Maryland 21651 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Chapel Cemetery | | | | 20c. Location - City or Town, State 7/21/99 Rock Hall, Maryland | | |
| 21. Signature of Funeral Service Licensee [Signature] | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BREAST CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 73 years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier [Signature] | | | | 29c. License number D41587 | | |
| 29d. Date signed (Month, Day, Year) 7/19/99 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, 122 Speer Road, Suite 5, Chestertown, Maryland 21620 | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[Faint, illegible handwritten notes visible through the paper.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24362

| | | | | | | | | |
|--|---|---|--|--|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard Carl Johnson | | | | 2. Date of Death Month Day Year 7 10 99 | | 3. Time of Death 8:37 AM | |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center | | | | 4b. City, Town, or Location of Death Clinton, MD | | 4c. County of Death Prince George | |
| Funeral Director | 5. Social Security Number 194-20-8122 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jun. 8, 1929 | 9. Birthplace (State or Foreign Country) W. Chester, PA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Prince George | | 10c. City, Town or Location Bowie | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 14405 Dunstable Court | | | | 10f. Zip Code 20721 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 2-13-51 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify African American | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | 16b. Kind of Business/Industry Medical | | |
| 17. Father's Name (First, Middle, Last) Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hattie Washington | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Susanne Johnson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14405 Dunstable Court Bowie, MD 20721 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rolling Green Mem. Park | | Date 7/15/99 | | 20c. Location - City or Town, State West Chester, PA | | |
| 21. Signature of Funeral Service Licensee <i>Dillon & Son</i> | | | | 22. Name and Address of Facility DeBaptiste Funeral Homes, Inc. Worthington & Miner Sts. West Chester, Pa 19382 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADULT RESPIRATORY DISTRESS SYNDROME 2 MONTHS Due to (or as a consequence of): b. MULTIPLE MYELOMA 2 YEARS Due to (or as a consequence of): c. SEPSIS 2 MONTHS Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>D. Gupta MD</i> | | 29c. License number D43346 | | 29d. Date signed (Month, Day, Year) 7/10/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Gupta MD. 8926 Woodlawn Rd # 201 Clinton, MD 20735 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 2 1999 | | 32. Registrar's Signature <i>Anna B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24363

| | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Wilhelmina Kunis | | | | 2. Date of Death Month Day Year July 15, 1999 | | | | 3. Time of Death 4:00 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) Genesis Eldercare - Spa Creek | | | | 4b. City, Town, or Location of Death Annapolis | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 141-54-1433 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 13, 1906 | | 9. Birthplace (State or Foreign Country) New Jersey | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 229 Via Dante Drive | | 10f. Zip Code 21012 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Home | |
| | 17. Father's Name (First, Middle, Last) Tunis Bos | | | | 18. Mother's Name (First, Middle, Maiden Summa) Margaret Van Dyke | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Margaret DeYoung/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 Via Dante Drive, Arnold, MD 21012 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fairlawn Cemetery | | Date July 19 1999 | | 20c. Location - City or Town, State Fairlawn, NJ | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): Deaths due to hip b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 3M | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Demerol | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D32036 | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) 7/16/99 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gay J. Sprave 2108 P. Dore Ave. Clark, MD 21619 | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature | | | | | | | |

Handwritten signature

JUL 5 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24364

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Omelia King

2. Date of Death

Month Day Year
July 19, 1999

3. Time of Death

7:38 A.M.

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

578-34-3973

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan. 19, 1929

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

301 Fairlea Road

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Office of the
Comptroller of Treasury

17. Father's Name (First, Middle, Last)

Daniel S. Walker

18. Mother's Name (First, Middle, Maiden Surname)

Susie America

19a. Informant's Name/Relationship (Type, Print)

Jack D. King/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 Fairlea Road Edgewater, Maryland 21037

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Meml. Gardens

Date

7-22-99

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lung Cancer

Due to (or as a consequence of):

c. Emphysema

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Atkinson, M.D.

470-D Ritchie Hwy. Severna Park, MD 21146

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1017 5 0 1888

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

AMEND:

#18 and
#6 mcg 7/14/99

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24365

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Grace Josephine Klimkiewicz

2. Date of Death
Month Day Year
July 10, 19993. Time of Death
2:00 am

4a. Facility Name (If not institution, give street and number)

2024 Gov. ThomasBLaden Way #104

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

578-18-9765

6. Sex

X F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

June 25, 1921

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2024 Gov. ThomasBLaden Way #104

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Hugh McCann

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite Malloy Molloy

19a. Informant's Name/Relationship (Type, Print)

Joan Marie Speaker / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2024 Gov. ThomasBLaden Way #104, Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mount Olivet Cemetery

Date

July 13
1999

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 2114623a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. metastatic cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Breast Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

00053306

29d. Date signed (Month, Day, Year)

7/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Curtis Harris M.D. 600 Ridgely Ave Annapolis MD 21401

31. Date filed (Month, Day, Year)

7/14 JUL 14 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JUL 14 1932

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24366

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank J. Kirchner, Sr.

2. Date of Death

Month Day Year
July 10 1999

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Spa Creek Ctr.

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

214-05-2749

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 13, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1954 Severn Grove Road

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Heavy Equip. operator

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John Kirchner

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Polk

19a. Informant's Name/Relationship (Type, Print)

Louise Kirchner / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1954 Severn Grove Rd. Annapolis, MD 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Cemetery

Date

7-13-99

20c. Location - City or Town, State

Annapolis, MD

21. Signature of Funeral Service Licensee

C Brian Powell

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

Congestive Heart Failure

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6M

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. J. Sprague

29c. License number

D32036

29d. Date signed (Month, Day, Year)

7/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gay J. Sprague 2108 P. Donohoe Drive Chesh, MD 21619

State
Registrar

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 5 7/19/99 CMH AACO HEALTH DEPT

99 24367

Reg. No.

| | | | | | | | | | | | | |
|--|---|---|--|---|---|--------------------------|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edith Kraft | | | | 2. Date of Death Month Day Year July 13, 1999 | | | | 3. Time of Death 12:55 A.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | | | 4c. County of Death Anne Arundel | | | |
| Funeral Director | 5. Social Security Number 377-12-7400 217-14-6220 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 | | 8. Date of Birth (Month, Day, Year) October 20, 1918 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Edgewater | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 225 Maryland Avenue, Edgewater, Md. | | | | 10f. Zip Code 21037 | | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Home | | | | |
| 17. Father's Name (First, Middle, Last) Ellis S. Lewis | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jessie I. Mohler | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles A. Kraft (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Maryland Ave., Edgewater, Maryland 21037-1560 | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | | | 20c. Location - City or Town, State 7-16-99 Brentwood, Maryland | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md 21037 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CLOSTRIDIUM DIFFICILE DIARRHEA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. EMPHYSEMA OSTEOPOROSIS MYELODYPLASIA | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D0052245 | | 29d. Date signed (Month, Day, Year) July 13, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL FREEDMAN, MD 205 RIDGELY AVENUE ANNAPOLIS, MD 21401 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | | | 32. Registrar's Signature | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24368

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anita Kearney

2. Date of Death
Month Day Year
July 18, 1999
3. Time of Death
5:28pm

4a. Facility Name (If not institution, give street and number)

9704 Sunset Drive

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

420-60-7655

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 5, 1936

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9704 Sunset Drive

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accounts Receivable Supervisor Automobile

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Euden Schonhaker

18. Mother's Name (First, Middle, Maiden Surname)

Katharina Hofnagel

19a. Informant's Name/Relationship (Type, Print)

William R. Kearney/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9704 Sunset Drive, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem.

Date

7/21/99

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Year

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD D44513

29d. Date signed (Month, Day, Year)

JULY 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sang-Kyune Lee, M.D., 15201 Shady Grove Road, # 202, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24369

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Edith Gertrude Kiss
2. Date of Death Month Day Year July 18, 1999
3. Time of Death 10:10 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number) 6108 Temple Street
4b. City, Town, or Location of Death Bethesda
4c. County of Death Montgomery

5. Social Security Number 141-32-7929
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 76 Yrs.
8. Date of Birth (Month, Day, Year) May 4, 1923
9. Birthplace (State or Foreign Country) Hungary

Usual Residence of Decedent

10a. State Maryland
10b. County Montgomery
10c. City, Town or Location Bethesda
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 6108 Temple Street
10f. Zip Code 20817
10g. Citizen of What Country? United States

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lab Technician
16b. Kind of Business/Industry Microbiology Company

17. Father's Name (First, Middle, Last) Not Available
18. Mother's Name (First, Middle, Maiden Sumame) Maria Not Available

19a. Informant's Name/Relationship (Type, Print) Elemer Adam Kiss/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2615 Davos Trail, Vail, Colorado 81657

20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. July 21, 1999
20c. Location - City or Town, State Bethesda, Maryland

21. Signature of Funeral Service Licensee M00689
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501

23a. Part I. Underlying disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. metastatic breast cancer 25 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier George A. Sotos, M.D.
29c. License number D43083
29d. Date signed (Month, Day, Year) July 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George A. Sotos, M.D. 9707 Medical Center Dr., #300, Rockville, MD 20850

31. Date filed (Month, Day, Year) JUL 21 1999
32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24370

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN KIVLAN

2. Date of Death

JULY

Day

16

Year

1999

3. Time of Death

2239

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OWES

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

523-09-8612

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

June 19, 1910

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3701 International Drive Apt. 711

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

John Kivlan

18. Mother's Name (First, Middle, Maiden Surname)

Anna Payton

19a. Informant's Name/Relationship (Type, Print)

Terence J. Kivlan (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3930 Connecticut Avenue, N.W. #405H Washington, D.C. 20008

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. John's Cemetery

Date

7/20/99

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Robert Ramsey

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INTER-TROCHANTERIC FRACTURE RT. HIP

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

JULY 12, 1999

28b. Time of Injury

UNKNOWN M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

FELL IN HIS HOME

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3701 INTERNATIONAL AVE SILVER SPRING, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MO. (OMT)

29c. License number

015236

29d. Date signed (Month, Day, Year)

JULY 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL MARGOLW, M.O. (OMT) 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State
Registrar

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

Beverly G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24371

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Helen Kostadinov</u> | | | | 2. Date of Death Month <u>July</u> Day <u>18</u> Year <u>1999</u> | | | | 3. Time of Death <u>01:06 AM.</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Calvert Memorial Hospital</u> | | | | 4b. City, Town, or Location of Death <u>Prince Frederick</u> | | | | 4c. County of Death <u>Calvert</u> | |
| Funeral Director | 5. Social Security Number <u>220-76-7016</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>60</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>January 16, 1939</u> | | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | |
| | Usual Residence of Decedent | | | | 10a. State <u>Maryland</u> | | 10b. County <u>Prince George</u> | | 10c. City, Town or Location <u>Greenbelt</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number <u>10L Plateau</u> | | 10f. Zip Code <u>20770</u> | | 10g. Citizen of What Country? <u>United States</u> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Accountant Supervisor</u> | | | | 16b. Kind of Business/Industry <u>Paint Manufacture</u> | |
| | 17. Father's Name (First, Middle, Last) <u>Harry Litts</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Florence Lanham</u> | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Michael J. Nance Jr. / Son</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>12649 Highsierra Drive Lusby, Maryland 20657</u> | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Fort Lincoln Crematory</u> | | 20c. Location - City or Town, State <u>7/22/99 Brentwood, Maryland</u> | | | | | |
| | 21. Signature of Funeral Service Licensee <u>Shaw E. Wells</u> | | | | 22. Name and Address of Facility <u>Fort Lincoln Funeral Home</u> <u>3401 Bladensburg Road Brentwood, Maryland 20722</u> | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| Physician /Medical Examiner | 23b. <u>Hypertensive and atherosclerotic Cardiovascular Disease</u> | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <u>Joseph Pestaner, MD.</u> | | | | 29c. License number <u>O.C.M.E.</u> | |
| | 29d. Date signed (Month, Day, Year) <u>July 18, 1999</u> | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Joseph Pestaner</u> <u>111 Penn Street, Baltimore, Maryland 21201</u> | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <u>JUL 21 1999</u> | | 32. Registrar's Signature <u>Brena G. Sparks</u> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text, possibly a signature or title, with a horizontal line underneath.

Handwritten text at the bottom of the page.

Handwritten text at the bottom right of the page.



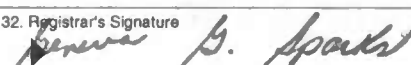
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24372

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NICOLAI KRAEMER | | | | 2. Date of Death Month JULY Day 16 , Year 1999 | | 3. Time of Death 11:40PM | |
| | 4a. Facility Name (If not institution, give street and number) ST. MARY'S HOSPITAL | | | | 4b. City, Town, or Location of Death LEONARDTOWN | | 4c. County of Death ST. MARY'S | |
| Funeral Director | 5. Social Security Number 556-42-5745 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) MARCH 20, 1914 | |
| | 9. Birthplace (State or Foreign Country) RUSSIA | | 10a. State MD. | | 10b. County ST. MARY'S | | 10c. City, Town or Location LEONARDTOWN | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 22680 CEDAR LA, | | 10f. Zip Code 20650 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BRICKMASON | | 16b. Kind of Business/Industry MASONRY | | | | |
| 17. Father's Name (First, Middle, Last) WILHELM FREDERICK KRAEMER | | | | 18. Mother's Name (First, Middle, Maiden Surname) EKERITHERINE GLASNOV | | | | |
| 19a. Informant's Name/Relationship (Type, Print) HELGA KRAEMER/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | Date 7/18/99 | | 20c. Location - City or Town, State RIVERDALE, MD. | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer of liver Due to (or as a consequence of): carcinoma colon Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death several months | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D 54346 | | 29d. Date signed (Month, Day, Year) 7/17/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHANDRA SAJJA HOLLYWOOD, MD. 20636 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME: NICOLAI KRAEMER

TO: DIRECTOR, CENTRAL INTELLIGENCE AGENCY

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

CLASSIFICATION: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24374

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KATHERINE MAE KOPPLEMAN

2. Date of Death

Month
07Day
18Year
99

3. Time of Death

6:55

4a. Facility Name (If not institution, give street and number)

DORCHESTER GENERAL HOSPITAL

4b. City, Town, or Location of Death

CAMBRIDGE

4c. County of Death

DORCHESTER

Funeral
Director

5. Social Security Number

215-36-1845

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
FEB. 20, 1937

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

DORCHESTER

10c. City, Town or Location

HURLOCK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4907 HARRISON FERRY ROAD

10f. Zip Code

21643

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

HEATING FUEL

17. Father's Name (First, Middle, Last)

WILBERT HANNIBAL HOFFMAN

18. Mother's Name (First, Middle, Maiden Surname)

EMMA LOUISE DISKAU

19a. Informant's Name/Relationship (Type, Print)

JEROME C. KOPPLEMAN, JR./HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4907 HARRISON FERRY ROAD, HURLOCK, MD 21643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EAST NEW MARKET CEMETERY

Date

7/21/99

20c. Location - City or Town, State

EAST NEW MARKET, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 207,
106 MAIN STREET, EAST NEW MARKET, MD 21631

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 hrs

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rectal Carcinoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43238

29d. Date signed (Month, Day, Year)

7/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Bair 19 Franklin St. Cambridge, MD 21613

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24375

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Emma Knotts

2. Date of Death

Month Day Year
July 23, 1999

3. Time of Death

1845

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

222-20-4320

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec 26, 1928

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Cordova

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

31016 Skipton Cordova Rd

10f. Zip Code

21625

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Harry Lemuel Collins

18. Mother's Name (First, Middle, Maiden Surname)

Edna Florence Davis

19a. Informant's Name/Relationship (Type, Print)

Brenda Lee Heinsohn Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31016 Skipton-Cordova Rd Cordova Maryland 21625

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Greensboro Cemetery

Date

July 26, 1999 Greensboro, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home PA

PO Box 160 Greensboro, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinomatosis ? lung or colon

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Smoker

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury of Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles E. DiNapoli, M.D.

29c. License number

D38990

29d. Date signed (Month, Day, Year)

7-24-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles E. DiNapoli, M.D., 404 MARVEL CT.
EASTON, MD, 21601

31. Date filed (Month, Day, Year)

JUL 28 1999

32. Registrar's Signature

B. G. Spaulding

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24376

Amended Item#5 perFH G774 8/10/99 EW

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|--|--|--------------------------|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Evelyn Tucker Lee | | | | 2. Date of Death Month Day Year July 19, 1999 | | | | 3. Time of Death 5:45 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Skyway Manor 1142 Skyway Dr. | | | | 4b. City, Town, or Location of Death Cape St. Claire | | | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 213-12-9841 577-12-3732 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) 9/25/1907 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | 10a. State Maryland | | | | 10b. County Anne Arundel | | 10c. City, Town or Location Mayo | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1300 Mayo Road | | | | 10f. Zip Code 21106 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Taxation | | | | 16b. Kind of Business/Industry State Government | | | |
| 17. Father's Name (First, Middle, Last) Weems Tucker | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alice (Unknown) | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Andrew Grubb (friend) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Mayo Rd. Mayo, MD 21106 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln | | Date 7/21/99 | | 20c. Location - City or Town, State Brentwood, MD | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility John M. Taylor 147 Duke of Gloucester St. 21401 | | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. Failure to Thrive | | | | | | | | | | 6 mons | |
| Due to (or as a consequence of): b. Anorexia intermittent | | | | | | | | | | 2 wks | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Senility | | | | | | | | | | 24 Months | |
| Due to (or as a consequence of): d. | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Group Hm | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Gary W Jones MD | | | | 29c. License number D30111 | | | | 29d. Date signed (Month, Day, Year) July 20, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary W Jones MD PO Box 385 Laurel Md 20725-0385 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 22 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature

NOT 23 200

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24377

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|-------------------------------------|---|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Linea H. Lee | | | | | 2. Date of Death Month Day Year July 15, 1999 | | 3. Time of Death 2:55PM | | |
| | 4a. Facility Name (If not institution, give street and number) Crofton Convalescent&Rehabilitation Center | | | | | 4b. City, Town, or Location of Death Crofton | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 216-82-3270 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 3, 1919 | | 9. Birthplace (State or Foreign Country) Sweden | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Edgewater | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 3728 Bay Dr. | | | | 10f. Zip Code 21037 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry At Home | | |
| | 17. Father's Name (First, Middle, Last) Erick Hagg | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edith J. Osterberg | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Eugene B. Lee, Jr./Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as Item 10 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens | | | Date 7/17/99 | | 20c. Location - City or Town, State Davidsonville, Md. | | |
| | 21. Signature of Funeral Service Licensee <i>George P. Kalas</i> | | | | | 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd. Edgewater, Md. 21037 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>coronary vascular disease</i> Due to (or as a consequence of): b. <i>hypertension</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>dementia</i> <i>fracture of hip</i> | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>Jeffrey Briggs MD</i> | | | | | 29c. License number D28640 | | 29d. Date signed (Month, Day, Year) July 16, 1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>2414 Hightee Ct. Crofton MD 21114</i> <i>JEFFREY BRIGGS, M.D.</i> | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 19 1999 | | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24378

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Lunacek, Sr.

2. Date of Death
Month Day Year
July 18, 1999

3. Time of Death
7:09 PM

4a. Facility Name (If not institution, give street and number)

775 Quince Orchard Boulevard, #21

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number
352-48-4127

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)
63 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
Jan. 18, 1936

9. Birthplace (State or Foreign Country)
Czech Republic

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

775 Quince Orchard Boulevard, #21

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Jan Lunacek

18. Mother's Name (First, Middle, Maiden Surname)

Lucie Richter

19a. Informant's Name/Relationship (Type, Print)

Frank Lunacek, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 East Scott Street, Chicago, Illinois 60610

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

7-20-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Delm

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC PROSTATIC CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy
performed?

☐ Yes ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

☐ Yes ☒ No

25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D22807

29d. Date signed (Month, Day, Year)

7/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward P. Gelmann, M.D., 3800 Reservoir Road, NW, Washington, DC 20007-2197

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24379

Certificate of Death

Reg. No.

| | | | | | | | |
|--|---|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EUNICE CONNIE LOCKHART | | | 2. Date of Death Month Day Year JULY 20 1999 | | 3. Time of Death 4:57pm | |
| | 4e. Facility Name (If not Institution, give street and number) CIVISTA MEDICAL CENTER | | | 4b. City, Town, or Location of Death LA PLATA | | 4c. County of Death CHARLES | |
| Funeral Director | 5. Social Security Number 451-42-5703 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan. 17, 1931 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | Usual Residence of Decedent | | | | |
| 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location Waldorf | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 44 Kings Wharf Place | | | 10f. Zip Code 20602 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service Worker | | 16b. Kind of Business/Industry Prince George's County | | |
| 17. Father's Name (First, Middle, Last) Henry Stevens Rickman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Elizabeth Scott | | | |
| 19a. Informant's Name/Relationship (Type, Print) Henrietta L. Faucette/Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Kings Wharf Place, Waldorf, Maryland 20602 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans' Cem. 7-27-1999 Cheltenham, Maryland | | Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee MARK G. BROHAWN MO0053 | | | | 22. Name and Address of Facility The Hunt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardiopulmonary Arrest Due to (or as a consequence of): b. Hyperkalemia Due to (or as a consequence of): c. Acute Renal Failure Due to (or as a consequence of): d. Hypotension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. e. Multi-organ failure Thrombocytopenia, Chronic Obstructive Pulmonary Disease | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier B. L. Jenkins | | | | 29c. License number D-33426 | | 29d. Date signed (Month, Day, Year) 7/20/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) B. LARRY JENKINS M.D. 111 LAGRANGE AVENUE P.O. BOX 1724 LA PLATA MD 20646 | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | 32. Registrar's Signature B. L. Jenkins | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

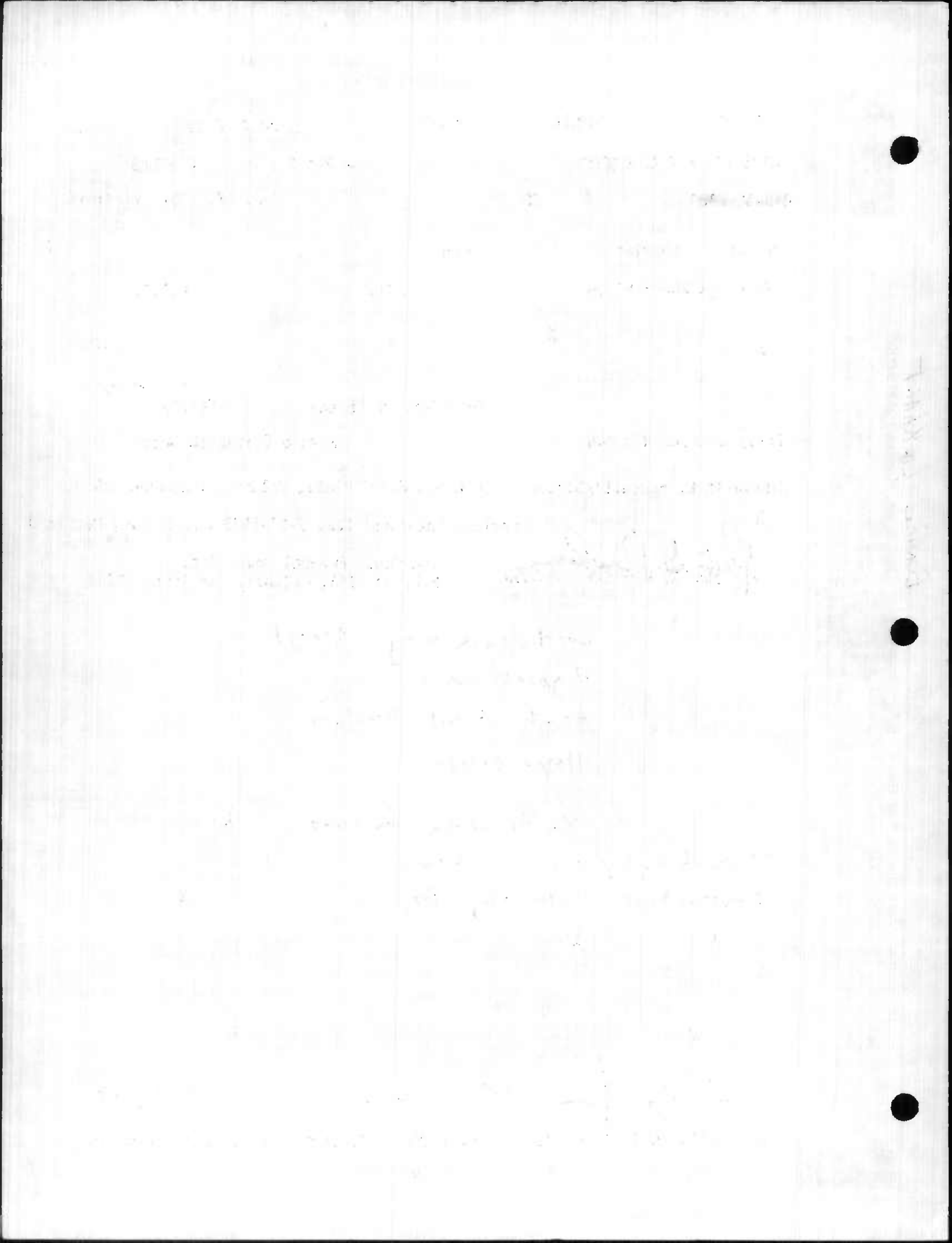
permil. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Eunice Lockhart
Baltimore, Maryland 21215-0020



Al

McMillan AMEND ITEMS: #23 PART I, 27 PER MEO G774 8-4-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24380

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALLEAN

L.

MCMILLAN

2. Date of Death

Month
JulyDay
10Year
1999

3. Time of Death

05:55 AM.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578 70 9485

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
April 10, 1950

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6325 Patterson Street

10f. Zip Code

20737

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

James Perry

18. Mother's Name (First, Middle, Maiden Surname)

Ludie Calloway

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Donnell (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 Jessup Blair Dr. #2, Silver Spring, MD. 20910

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

7/20/99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service Inc.

7400 Georgia Ave., N.W., Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural
☐ Accident
☐ Suicide
☐ Homicide5. Pending investigation
6. Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician:☒ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

Jennifer B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24381

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gina Mary Manning

2. Date of Death

Month Day Year
July 17, 1999

3. Time of Death

10:35PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

9405 Duxford Court

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

277-94-3693

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

36

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 22, 1962

9. Birthplace (State or Foreign Country)

Guam

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14416 Parkvale Rd. #2

10f. Zip Code

20853

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Contract Administrator

16b. Kind of Business/Industry

Kaiser Permanente

17. Father's Name (First, Middle, Last)

Kenneth M. Manning

18. Mother's Name (First, Middle, Maiden Surname)

Geraldine A. Bell

19a. Informant's Name/Relationship (Type, Print)

Kenneth M. Manning-Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9405 Duxford Ct. Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery 7/22/99

Date

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Thomas E. Honnaker

22. Name and Address of Facility

Joseph Gawler's Sons Inc, 5130 Wisconsin Ave.
NW, Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Breast Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

12 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Parents Home

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph Kaplan MD.

29c. License number

D35635

29d. Date signed (Month, Day, Year)

July 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan MD., 18111 Prince Phillip Dr. #327, Olney, MD 20832-1513

State
Registrar

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

Jennifer B. Sparks

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 24382**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

L. Edward Mason

2. Date of Death
Month Day Year
July 18 1999
3. Time of Death
19:20

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

579-01-3930

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 24, 1914

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

136 East Lake Drive

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Construction Inspector

16b. Kind of Business/Industry

U.S. Govt.

17. Father's Name (First, Middle, Last)

Lewis A. Mason

18. Mother's Name (First, Middle, Maiden Surname)

Grace Snediker

19a. Informant's Name/Relationship (Type, Print)

Margaret Mason / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

136 East Lake Dr. Annapolis, MD 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Mem. Gardens

Date

7-23-99

20c. Location - City or Town, State

Rockville, MD.

21. Signature of Funeral Service Licensee

E. Brian Powell

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Myocardial Infarction

Approximate Interval Between Onset and Death

1 hr

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Alcohol Abuse

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

E. Brian Powell

29c. License number

D38158

29d. Date signed (Month, Day, Year)

7/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LISA A DINEEN MD 2003 Medical Parkway, Suite 100 Annapolis MD

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

Benita B. Sparks

2/401

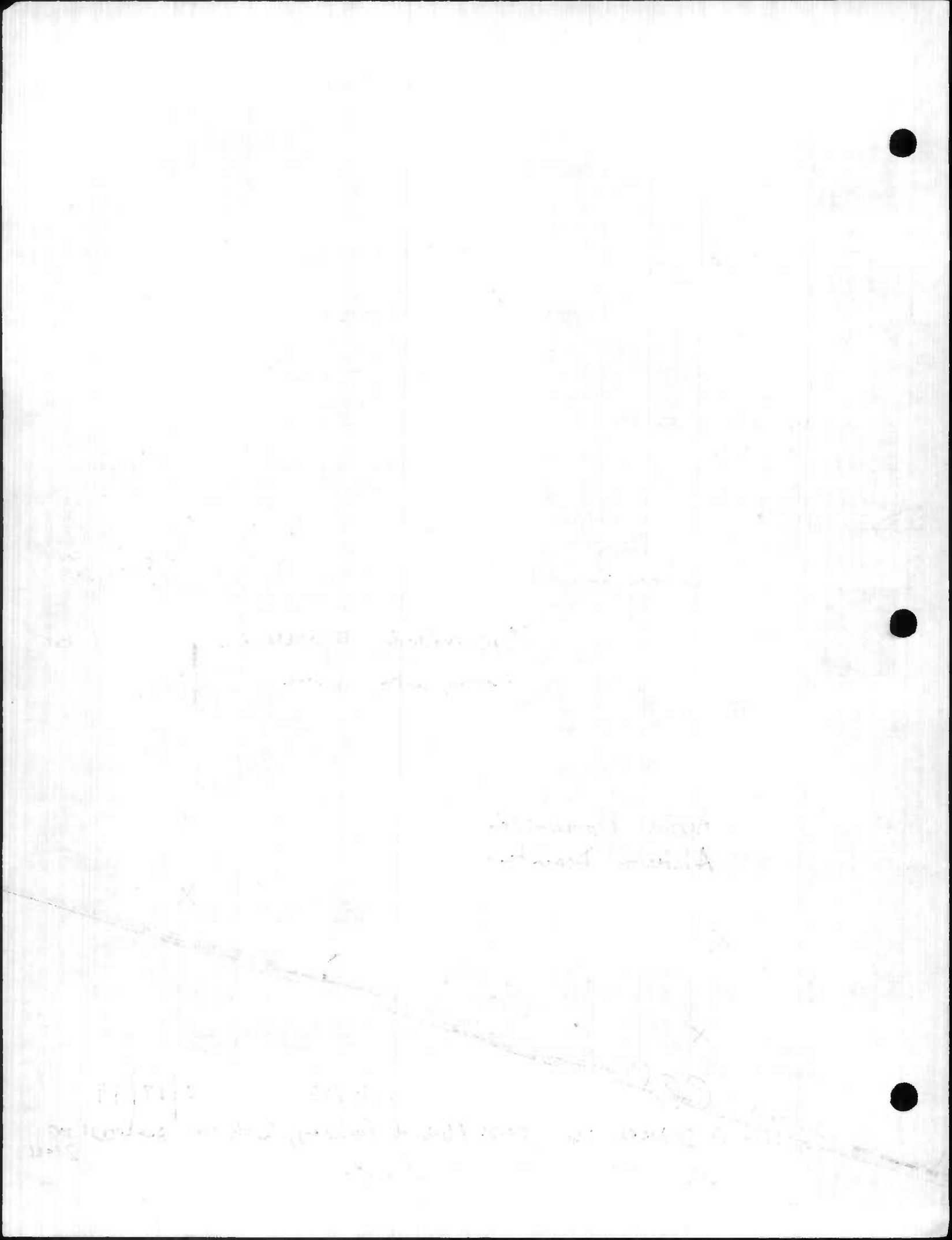
State
Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24383

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Baugh McFarland

2. Date of Death

July 17 1999

3. Time of Death

8:05 PM

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

579-20-4108

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 21, 1922

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

2 ☒ Yes 2 ☐ No

10e. Street and Number

90 Monroe Street, #504

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Sears Dept. Store

17. Father's Name (First, Middle, Last)

Byron Baugh

18. Mother's Name (First, Middle, Maiden Surname)

Emma ?

19a. Informant's Name/Relationship (Type, Print)

Penny Kirby (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11801 Rockville Pike, #1101, Rockville, MD 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan F/Serv 7/19/99 Alexandria, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Carcinoma of the Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wesley B. Mason, M.D.

29c. License number

D22235

29d. Date signed (Month, Day, Year)

7/18/1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Wesley B. Mason, M.D., 10810 Connecticut Ave, Kensington, MD., 20895

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

*Geneva B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

My dear Mr. Wright -

I have just received your letter of the 12th inst.

and am glad to hear from you.

I am well and hope these few lines will find you the same.

I have not much news to write at present.

I am, however, very anxious to hear from you again.

I am, dear Mr. Wright, very truly yours,

Wm. Lloyd Garrison

P.S. - I have just received your letter of the 12th inst.

and am glad to hear from you.

I am well and hope these few lines will find you the same.

I have not much news to write at present.

I am, however, very anxious to hear from you again.

I am, dear Mr. Wright, very truly yours,

Wm. Lloyd Garrison

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24384

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|--|--|---|--|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary K. Macfarlane | | | | 2. Date of Death Month Day Year July 21, 1999 | | | | 3. Time of Death 5:49pm | | |
| | 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Nursing & Rehab. | | | | 4b. City, Town, or Location of Death Rockville | | | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 164-09-3068 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept 26, 1914 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Montgomery | | |
| 10c. City, Town or Location Rockville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 8 Baltimore Road | | | |
| 10f. Zip Code 20850 | | | | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | |
| 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Gustav F. Rees | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Ploppert | | | | 19a. Informant's Name/Relationship (Type, Print) John F. Macfarlane/ Son | | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 917 Montrose Road, Rockville, MD 20852 | | | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | | |
| 20c. Location - City or Town, State Silver Spring, MD | | | | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd.W., Silver Spring, MD 20901 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Osteoarthritis</u> Due to (or as a consequence of): c. <u>Dementia</u> Due to (or as a consequence of): d. <u>Osteoporosis</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | |
| 29c. License number D4327 | | | | 29d. Date signed (Month, Day, Year) July 22, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunita Hanjura 809 Veirs Mill Road #101, Rockville, MD 20851 301-762-5019 | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

12

State
Registrar

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24385

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Edward Mochwart

2. Date of Death

Month Day Year
July 17, 1999

3. Time of Death

11:50 PM

4a. Facility Name (If not Institution, give street and number)

Manor Care Chevy Chase

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-46-0535

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 8, 1934

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4620 North Park Avenue, #1410E

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Russell Calvin Mochwart

18. Mother's Name (First, Middle, Maiden Summa)

Myrtle Smith

19a. Informant's Name/Relationship (Type, Print)

Deborah Worthington Mochwart (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7401 Westlake Terrace, #104, Bethesda, MD 20817

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

7-19-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Nelson

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Synovial Sarcoma

Approximate
Interval Between
Onset and Death

3 years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David C. Luthringer

29c. License number

D0013771

29d. Date signed (Month, Day, Year)

July 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Luthringer, M.D., 5530 Wisconsin Avenue, #1240, Chevy Chase, MD

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24386

| | | | | | | | | |
|--|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ellen Molnar | | | | 2. Date of Death Month Day Year JULY 17 1999 | | 3. Time of Death 12:13 A.M. | |
| | 4e. Facility Name (If not institution, give street and number) MALCOLM GROW MEDICAL CENTER | | | | 4b. City, Town, or Location of Death CAMP SPRINGS | | 4c. County of Death PRINCE GEORGE'S | |
| Funeral Director | 5. Social Security Number 181-18-2928 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) June 25, 1920 | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State VA | | 10b. County Fairfax | | 10c. City, Town or Location Alexandria | |
| Usual Residence of Decedent | | 10e. Street and Number 1048 Dalebrook Drive | | 10f. Zip Code 22308 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Manufacturing | | | | |
| 17. Father's Name (First, Middle, Last) John Zorek | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sophie Deptuch | | | | |
| 19a. Informant's Name/Relationship (Type, Print) (Husband) Col. Alexander A. Molnar | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1048 Dalebrook Drive Alexandria, VA 22308 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Park | | 20c. Date 7/21/99 | | 20d. Location - City or Town, State Hermitage, PA | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>a. METASTATIC MALIGNANCY WITH ASCITES 6 MONTHS</p> <p>b. COLON CANCER STAGE 4 3 YEARS</p> <p>c.</p> <p>d.</p> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION H/O DVT; ANTICOAGULANT ON HEPARIN ANEMIA | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number NYS 140658-1 | | 29d. Date signed (Month, Day, Year) JULY 17 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LEON W. KUNDROTAS, COL, USAF, MC | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANDREWS AIR FORCE BASE MD 20762 | | | | |
| 31. Date filed (Month, Day, Year) JUL 19 1999 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24387

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Viola Gertrude Massey | | | | 2. Date of Death Month Day Year July 13, 1999 | | 3. Time of Death 4:50 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) Corsica Hills Nursing Home | | | | 4b. City, Town, or Location of Death Centreville | | 4c. County of Death Queen Annes | |
| Funeral Director | 5. Social Security Number 219-07-6562 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) May 30, 1906 | |
| | 9. Birthplace (State or Foreign Country) Pondtown, Maryland | | 10a. State Maryland | | 10b. County Queen Annes | | 10c. City, Town or Location Chestertown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 220 Pine Tree Road | | 10f. Zip Code 21620 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Processor | | 16b. Kind of Business/Industry Pickling Plant | | | |
| | 17. Father's Name (First, Middle, Last) Joseph Massey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anne Gertrude Tiller | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Gloria Cooper/Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 Pondtown Road, Chestertown, Maryland 21620 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Pleasant Cemetery/July 17, 1999 | | 20c. Location - City or Town, State Pondtown, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. PO Box 270, Millington, Maryland 21651-0270 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardio pulmonary Arrest</i> Due to (or as a consequence of): b. <i>Colon Carcinoma</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Large Abdominal Mass Secondary to Colon Carcinoma.</i> | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) <i>None</i> | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>J. C. Anaball Jr. M.D.</i> | | | | 29c. License number <i>823829</i> | | 29d. Date signed (Month, Day, Year) <i>7/14/99</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>John C. Anaball Jr. M.D., 948 Washington Ave, Chestertown, MD 21620</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year) <i>JUL 16 1999</i> | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24388

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Blaine Sigler MacDannald

2. Date of Death
Month Day Year
July 9, 19993. Time of Death
9:59 a.m.

4a. Facility Name (If not institution, give street and number)

300 Hadaway drive Apt. 9 D

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral
Director

5. Social Security Number

207 09 0667

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 13, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

300 Hadaway Drive Apt 9 D

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
2 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Pharmaceutical

17. Father's Name (First, Middle, Last)

James Guy MacDannald

18. Mother's Name (First, Middle, Maiden Surname)

Bertha M. Weaver

19a. Informant's Name/Relationship (Type, Print)

Carol E. Drown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3302 E. Presidio Rd Tucson, AZ 85716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Md. Veterans Cemetery

Date

7/16

20c. Location - City or Town, State

Hurlock, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein, & Newnam Funeral Home
130 Speer Rd. Chestertown, Md. 2162023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Lower GI. Bleed.

Approximate
Interval Between
Onset and Death

< 24

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DM Type II, Afib, BPH, COPD, HH,
PUD₃, Glaucoma, Peripheral Vasc D₃

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Neil Stoddard MD

29c. License number

D 50996

29d. Date signed (Month, Day, Year)

7/9/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Neil Stoddard MD 100 Brown St. Chestertown MD 21620

State
Registrar

31. Date filed (Month, Day, Year)

JUL 13 1999

32. Registrar's Signature

Benjamin G. Sparks

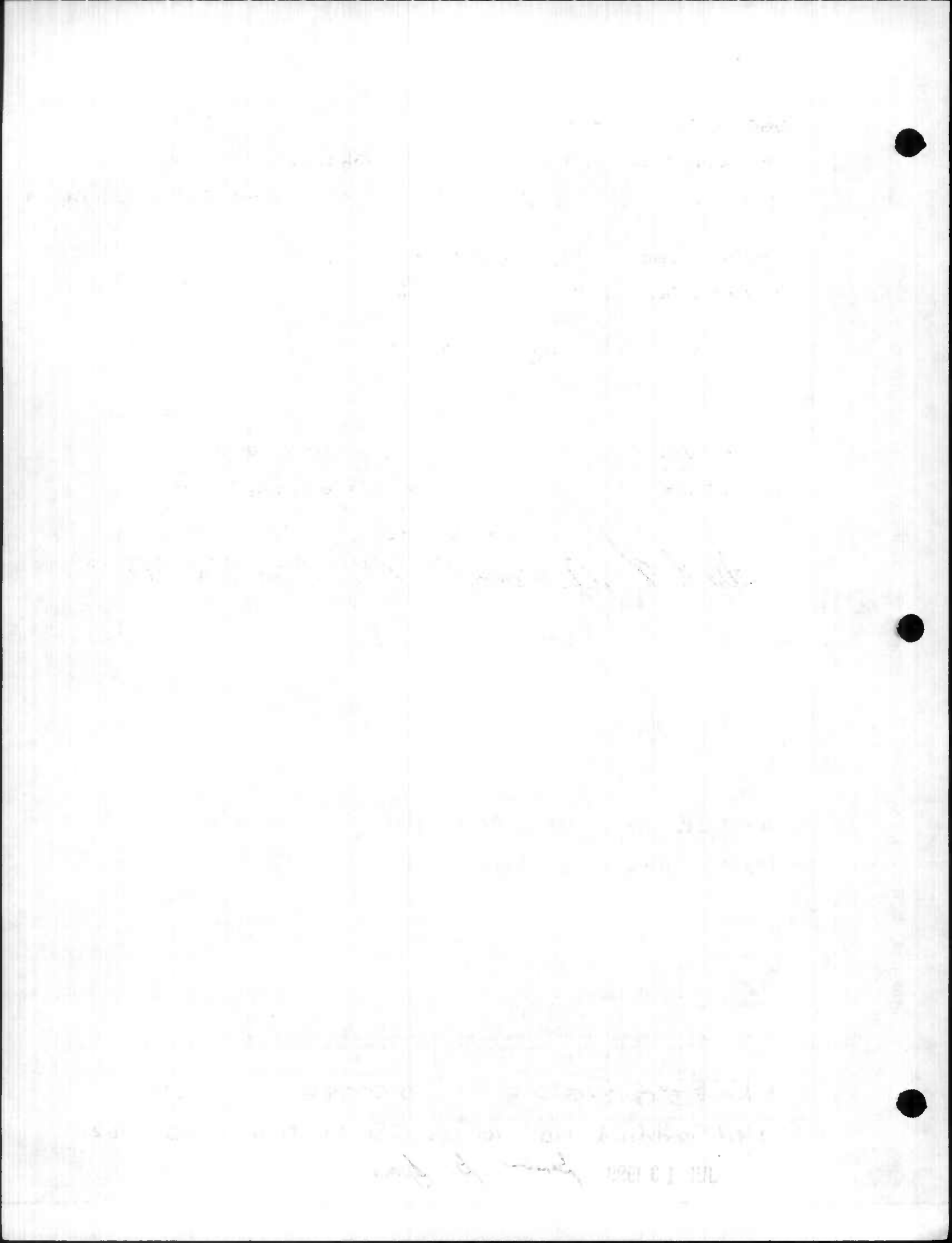
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-1000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24389

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Alice Stafford Moore

2. Date of Death

Month Day Year
July 16, 1999

3. Time of Death

7:00 p.m.

4a. Facility Name (If not institution, give street and number)

Corsica Hills Nursing Center

4b. City, Town, or Location of Death

Centreville

4c. County of Death

Queen Anne's

5. Social Security Number

216-10-3906

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 28, 1905

9. Birthplace (State or Foreign Country)

Grassville, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Rock Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

PO BOX 271

10f. Zip Code

21661

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Charles R. Stafford

18. Mother's Name (First, Middle, Maiden Surname)

Alice M. Stafford

19a. Informant's Name/Relationship (Type, Print)

Virginia Rhoades/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

152 Kings Highway, Lewes, DE 19958

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesterfield Centery

Date

7/21/99

20c. Location - City or Town, State

Centreville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.

130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 min.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atrial fibrillation

Due to (or as a consequence of):

1 yr.

c. (P) hip fracture

Due to (or as a consequence of):

2 wks.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Congestive heart failure

Anemia, iron deficient

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D51735

29d. Date signed (Month, Day, Year)

7/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Delboy, 6602 Church Hill Road, Suite 200, Chestertown, MD 21620

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24390

AMEND ITEM# 1 PER MD G775 9-1-99 WR.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|-----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLES MANN CHARLES Armistead MANN | | | | 2. Date of Death Month Day Year JULY 29 1999 | | 3. Time of Death 23:10 | |
| | 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 212-32-1044 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 29, 1924 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Randallstown (Granite) | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2916 Offutt Road | | | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) 3 + | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy Farmer | | 16b. Kind of Business/Industry Self-Employed | | |
| 17. Father's Name (First, Middle, Last) Thomas Armistead Mann | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sarah Margaret Amelia Rinker | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Jane A. Mann - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2916 Offutt Road; Randallstown (Granite), MD. 21133 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Svc., Inc. 7/31/99 Hampstead, Maryland | | Date | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s. Sepsis Due to (or as a consequence of): b. Renal failure Due to (or as a consequence of): c. Pulmonary fibrosis Due to (or as a consequence of): d. Cardiogenic shock | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number P 113 90 | | 29d. Date signed (Month, Day, Year) JULY 29, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ITONA SABKA, MD 5601 WOOD LAVERN BLVD, BALTIMORE, MD 21239 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 02 1999 | | | | 32. Registrar's Signature | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 4C 7/16/99 AACO HEALTH DEPT CMH

Certificate of Death

Reg. No.

99 24391

| | | | | | | | | | | | |
|---|--|---|--|--|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Niesz | | | | 2. Date of Death Month Day Year July 12 1999 | | | | 3. Time of Death 17:22 | | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center 22 S. Greene Str. | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death Baltimore City | | |
| Funeral Director | 5. Social Security Number 216-50-3521 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 51 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 30, 1947 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 590 Melissa Court | | | | 10f. Zip Code 21012 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam War | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner of Dental Lab | | | | 16b. Kind of Business/Industry Dentistry | | | |
| 17. Father's Name (First, Middle, Last) Jacob Niesz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Howe | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Donna Niesz/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 590 Melissa Court Arnold, MD 21012 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial | | Date July 16 1999 | | 20c. Location - City or Town, State Davidsonville, MD | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Severna Park, MD 21146 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number P 11735 | | | | 29d. Date signed (Month, Day, Year) July 13, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBRA M. BENSON 22 S. GREENE ST. BALTIMORE MD | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 16 1999 | | 32. Registrar's Signature | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

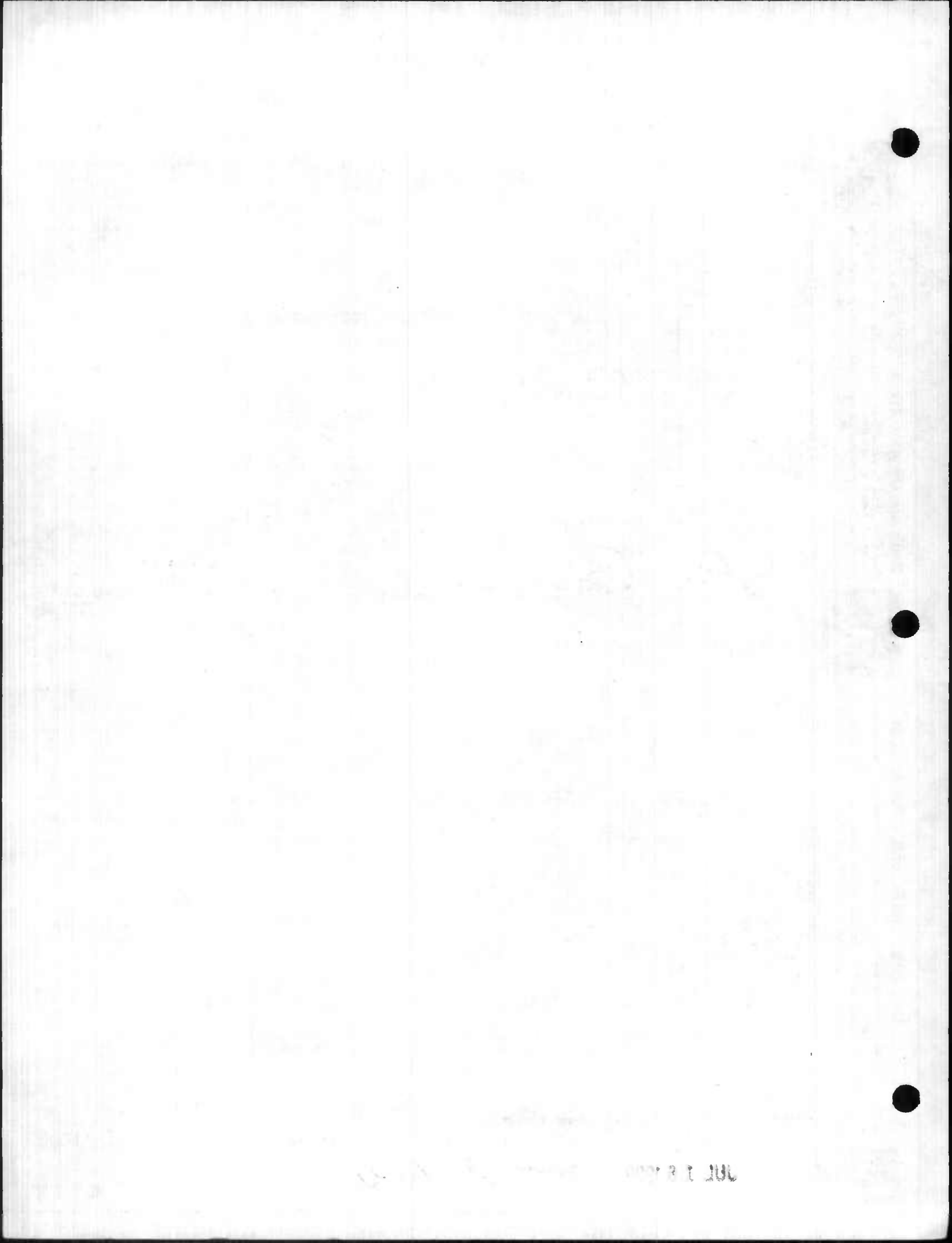
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



JUL 18 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24392

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bertha Odom

2. Date of Death

July 19, 1999

3. Time of Death

6:10 am

4a. Facility Name (If not institution, give street and number)

Manor Care Nursing Home

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

466-30-6136

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
October 22, 1920

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2022 Klinge Road NW

10f. Zip Code

20010

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, Whites, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Walter Ross

18. Mother's Name (First, Middle, Maiden Surname)

Alice Littlefield

19a. Informant's Name/Relationship (Type, Print)

Marian Johnson / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2022 Klinge Rd NW D.C. 20010

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Mausoleum

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

7/22/99

20c. Location - City or Town, State

Brentwood Maryland

21. Signature of Funeral Service Licensee

Sharon E. Wells

22. Name and Address of Facility

Fort Lincoln Funeral Home

3401 Bladensburg Road Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Artherosclerotic Heart Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart FailureRenal InsufficiencyCerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D33357

29d. Date signed (Month, Day, Year)

7/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee Jonathan Musher mss 5530 Wisconsin Ave Chevy Chase mss

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24393

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ELEANOR PARKER

2. Date of Death
Month Day Year
JULY 15 19993. Time of Death
11:20 pm

4a. Facility Name (If not institution, give street and number)

ANNAPOLIS NURSING & REHAB. CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

215-32-7107

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT. 11 1939

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1916 COPELAND STREET

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

GEORGE CREEK

18. Mother's Name (First, Middle, Maiden Summa)

BESSIE SIMMS

19a. Informant's Name/Relationship (Type, Print)

JOANN PARKER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1916 F. COPELAND ST. ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ADAMS CHURCH CEMETERY

Date

7/20/99

20c. Location - City or Town, State

LOTHIAN, MD.

21. Signature of Funeral Service Licensee

Larry J. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Gangrene

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 mo

6 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brian S. Kahan, DO

29c. License number

H53803

29d. Date signed (Month, Day, Year)

7/19/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Brian S. Kahan, DO 1610 West St #110 Annapolis, Md. 21401

State
Registrar

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

Brian S. Kahan

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1000 1000 1000

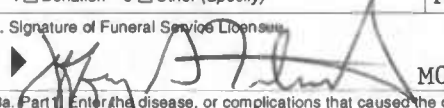
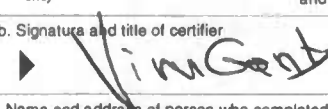

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24394

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Narendra C. Pant | | | | 2. Date of Death Month Day Year July 17, 1999 | | 3. Time of Death 5:05PM | |
| | 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number N/A | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) January 24, 1924 | 9. Birthplace (State or Foreign Country) India |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State - | | 10b. County - | | 10c. City, Town or Location Bangalore, India | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 456, 11th B. Cross, J.P. Nagar | | | | 10f. Zip Code 560 078 | | 10g. Citizen of What Country? India | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Indian | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) - College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Director | | | 16b. Kind of Business/Industry Entomology Institute | |
| 17. Father's Name (First, Middle, Last) Ram Datt Pant | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Chandrawati Joshi | | | |
| 19a. Informant's Name/Relationship (Type, Print) Vibha Pant/ Daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Rock Lodge Road, Gaithersburg, MD 20877 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | | 20c. Location - City or Town, State Bethesda, Maryland | | |
| 21. Signature of Funeral Service Licensee  M00689 | | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myeloid Leukemia Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Acute Respiratory Failure Due to (or as a consequence of): d. Acute renal Failure Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Coronary Artery Disease Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D41162 mb | | 29d. Date signed (Month, Day, Year) July 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti, M.D. 10810 Darnestown Road, #H-1, Gaithersburg, Maryland 20878 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24395

Amend #5, 7/22/99, BMW, Montg. Co.

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CARROLL W. PLUMMER | | | | 2. Date of Death Month JULY Day 15 Year 1999 | | 3. Time of Death 0015 | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 220-28-5657 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 14, 1933 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Olney | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 18305 Wachs Terrace | | | | 10f. Zip Code 20832 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2nd Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscape Foreman | | | 16b. Kind of Business/Industry Landscape | |
| 17. Father's Name (First, Middle, Last) Earl Plummer | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Simms | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Dellie V. Plummer (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18305 Wachs Ter., Olney, MD 20832 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan F/Serv | | Date 7/19/99 | | 20c. Location - City or Town, State Alexandria, VA | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Anoxic Encephalopathy Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Status post lobectomy Due to (or as a consequence of): d. | | | | | | | | Approximate interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Chronic Obstructive pulmonary disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D 23170 | | 29d. Date signed (Month, Day, Year) 7/15/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gita Bakshi, M.D. 9406 Old Georgetown Rd., Bethesda, MD 20814 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24396

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SELIM S. PODNOS | | | | 2. Date of Death Month Day Year 07.20.1999 | | 3. Time of Death 10:14 AM | | |
| | 4e. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | | |
| Funeral Director | 5. Social Security Number 194.12.1609 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) 04.02.1915 | | |
| | 9. Birthplace (State or Foreign Country) MASS. | | 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location ROCKVILLE | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 6121 MONTROSE ROAD | | 10f. Zip Code 20852 | | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER | | | | 16b. Kind of Business/Industry FEDERAL GOVERNMENT | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) ALEXANDER PODNOS | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA GROSS | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) MARC W. PODNOS/SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 LYNN MANOR DRIVE, ROCKVILLE, MARYLAND 20850 | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GARDENS | | 20c. Location - City or Town, State 7.22.99 OLNEY, MARYLAND | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA, VASCULAR | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D 18084 | | | | 29d. Date signed (Month, Day, Year) JULY 20, 1999 | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.D. PATEL, M.D. - 6121 MONTROSE RD, ROCKVILLE, MD 20852 | | | | 31. Date filed (Month, Day, Year) JUL 23 1999 | | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature | | | | 33. State Registrar JUL 23 1999 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

GOTTLIEB PRICE

2. Date of Death

Month Day Year
JULY 14, 1999

3. Time of Death

11:30AM

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

MONTGOMERY

5. Social Security Number

112-05-9177

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 29, 1906

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10529 Truxton Road

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Bread Salesman

16b. Kind of Business/Industry

Food Services

17. Father's Name (First, Middle, Last)

Albert Price

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Hillman

19a. Informant's Name/Relationship (Type, Print)

Daniel Price (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10529 Truxton Rd., Adelphi, MD 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beth David Cemetery

Date

7/15/99 Long Island, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF PANCREAS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 18084

29d. Date signed (Month, Day, Year)

JULY 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. D. PATEL, M.D. 612, MONTROSE RD, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24398

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LUCY CORENE TOLSON PROUT | | | | 2. Date of Death Month Day Year JULY 22, 1999 | | 3. Time of Death 12:23 PM | |
| | 4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death CLINTON | | 4c. County of Death PRINCE GEORGE | |
| Funeral Director | 5. Social Security Number 225-16-1101 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 17, 1922 | |
| | 9. Birthplace (State or Foreign Country) VIRGINIA | | 10a. State MARYLAND | | 10b. County PRINCE GEORGE | | 10c. City, Town or Location FORT WASHINGTON | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 11707 HICKORY DRIVE | | 10f. Zip Code 20744 | | 10g. Citizen of What Country? UNITES STATES | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | 16b. Kind of Business/Industry PRIVATE | | 17. Father's Name (First, Middle, Last) WALTER TOLSON | | |
| 18. Mother's Name (First, Middle, Maiden Surname) BERTHA MONROE TOLSON | | 19a. Informant's Name/Relationship (Type, Print) GLORIA PROUT / DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11707 HICKORY DRIVE FORT WASHINGTON, MD 20744 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) SHILOH CHURCH CEMETERY | | 20c. Location - City or Town, State NEWBURG, MARYLAND | | 21. Signature of Funeral Service Licensee  LEON THORNTON | | 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADENOCARCINOMA OF PANCREAS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | Approximate Interval Between Onset and Death 3 YEARS | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE ON CHRONIC RENAL FAILURE. ENCEPHALOPATHY DIABETES MELLITUS | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) _____ | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred _____ | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) _____ | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) _____ | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier  Pamela Guna M.D. | | 29c. License number 00016116 | | 29d. Date signed (Month, Day, Year) 23rd July, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAMELA GUNA M.D., 8926 WOODYARD ROAD #501 CLINTON MD 20735 | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | 32. Registrar's Signature  B. Sparks | | State Registrar | | Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text covering the page, possibly bleed-through from the reverse side. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24399

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN REBECCA PICKERAL

2. Date of Death
Month Day Year
July 20 1999

3. Time of Death
8:30 pm

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

214-28-4455

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 27, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27094 Baptist Church Road

10f. Zip Code

20659

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Explosive Operator

16b. Kind of Business/Industry

Federal Govt.

17. Father's Name (First, Middle, Last)

Townley Pickeral

18. Mother's Name (First, Middle, Maiden Summa)

Maggie Pickeral

19a. Informant's Name/Relationship (Type, Print)

Janet Wheatley/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27094 Baptist Church Rd. Mechanicsville, MD 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oakland Cemetery

Date

7/23/99 Waldorf, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME P.A.
P.O. BOX 567 LA PLATA, MD 20646

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation
Due to (or as a consequence of):
b. Congestive Heart Failure
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

immediates
5 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus
Organic Brain Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D - 0052741

29d. Date signed (Month, Day, Year)

7/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12070 Old Line Center

Caroline J. Caine, MD Suite 100, Waldorf, Maryland 20602

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

[Signature]

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

HELEN PICKERAL
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24400

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Joyce ANN Pinder

2. Date of Death
Month Day Year

July 18, 1999

3. Time of Death

1357

4a. Facility Name (If not institution, give street and number)

Prince Georges County Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

214-60-9257

6. Sex

1 ☐ M 2 ☒ F

7. Age (In Yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 06, 1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1611 WARREN AVENUE

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Day Care Provider

16b. Kind of Business/Industry

Entrepreneur

17. Father's Name (First, Middle, Last)

Benjamin Nathaniel Robinson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Mae Chester

19a. Informant's Name/Relationship (Type, Print)

Elsie Stanley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4636 Golden Hill Rd. Church Creek, MD. 21622

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Madison Cemetery

Date

7/24/99

20c. Location - City or Town, State

Woolford, MD

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

HENRY FUNERAL HOME P.A.
510 Washington St. Cambridge, MD. 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIOPULMONARY ARREST

a. Due to (or as a consequence of):

CARDIAC ARRHYTHMIA

b. Due to (or as a consequence of):

Acute myocardial INFARCTION -

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION -

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anil K. Mahajan MD

29c. License number

D50689

29d. Date signed (Month, Day, Year)

07/18/1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANIL K. MAHAJAN PGHOSPITAL EMERGENCY DEPARTMENT DRIVE.

3001 HOSPITAL

CHEVERLY, MD 20785

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

[Signature]

State Registrar

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24401

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Toribia G. Rodriguez | | | | 2. Date of Death Month July Day 12 Year 1999 | | 3. Time of Death 2:05AM | | |
| | 4a. Facility Name (If not institution, give street and number) Manor Care-Fernwood | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 224-80-4885 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) April 17, 1917 | | |
| | 9. Birthplace (State or Foreign) Republic of Trinidad | | 10a. State N/A | | 10b. County N/A | | 10c. City, Town or Location Washington, DC | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 3023 14th St. NW #311 | | 10f. Zip Code 20001 | | 10g. Citizen of What Country? U.S.A | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper | | 16b. Kind of Business/Industry Maintenance | | | | | |
| 17. Father's Name (First, Middle, Last) Eusibio Rodriguez | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Natividad Boney | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Adonis-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 Newton St. NW, #302, Washington, DC 20010 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date 7/24/1999 | | 20c. Location - City or Town, State Silver Spring, MD | | | |
| 21. Signature of Funeral Service Licensee Thomas E. Honnaker | | | | 22. Name and Address of Facility Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Leukemia Due to (or as a consequence of): b. Endometrial Cancer Due to (or as a consequence of): c. Hydronephrosis Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Renal Insufficiency | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Kirti Vohra M.D | | 29c. License number D20274 | | 29d. Date signed (Month, Day, Year) July 13, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirti Vohra MD., 5630 Shields Dr., Bethesda, MD 20817 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature Renata B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

1971 12 28

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24402

| | | | | | | | | | | |
|---|--|--|---|---------------------------------|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ann L. Reuther | | | | 2. Date of Death Month Day Year July 9 1999 | | | | 3. Time of Death 7:00pm | |
| | 4a. Facility Name (If not institution, give street and number) Genesis Nursing Home | | | | 4b. City, Town, or Location of Death Annapolis | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 233-03-1895 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) 1/2/1917 | | 9. Birthplace (State or Foreign Country) Ohio | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 43 W. McKinsey Rd. | | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Home | |
| | 17. Father's Name (First, Middle, Last) William E. Ackermann, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Louise Fehrenbach | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Edward E. Reuther | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 W. McKinsey Rd. Severna Park MD 21146 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery | | Date 7/12 | | 20c. Location - City or Town, State Crownsville, MD | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park F.H. 495 Ritchie Hwy Severna Park MD 21146 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Alzheimers Disease</u> Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 4 years | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D0029571 | | | | 29d. Date signed (Month, Day, Year) 7/11/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Berez MD 1655 Crofton Blvd Suite 101 Crofton MD 21114 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | 32. Registrar's Signature | | | | | | | | |

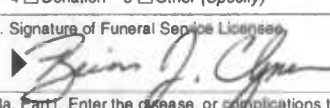
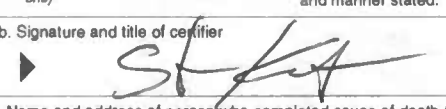
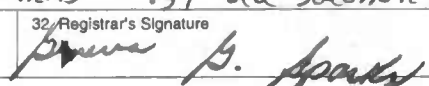
1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND# 16A 7/14/99 AACO HEALTH CMH **Certificate of Death**

Reg. No.

99 24403

| | | | | | | | | |
|--|--|---|--|---|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Leon Romo | | | | 2. Date of Death Month July Day 12 Year 1999 | | 3. Time of Death 12:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 569-01-2165 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 9, 1921 | 9. Birthplace (State or Foreign Country) California |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 1611 Harmony Acres Lane | | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ATHLETIC Trainer | | 16b. Kind of Business/Industry Sports Medical | | |
| 17. Father's Name (First, Middle, Last) Juan Romo | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James Romo (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Locust Ave. Annapolis, MD 21401 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery | | Date 7/15/99 | | 20c. Location - City or Town, State Annapolis, MD |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. malnutrition Due to (or as a consequence of): b. Cerebrovascular Accident Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 3 months 3 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HyperTENSION, Dementia | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | 29c. License number D38687 | | 29d. Date signed (Month, Day, Year) 7/12/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN J KATZ M.D. 139 Old Solomon's Island Rd, Annapolis MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24404

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Angelo Ripoli

2. Date of Death
Month Day Year
July 21, 19993. Time of Death
12:05 PM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

177-10-8638

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 20, 1907

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

101 Odendhal Avenue, # 712

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Chair Factory

17. Father's Name (First, Middle, Last)

Nicholas

Ripoli

18. Mother's Name (First, Middle, Maiden Summa)

M. Philomena

Buccarato

19a. Informant's Name/Relationship (Type, Print)

Evelyn J. Ripoli/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Odendhal Ave., # 712, Gaithersburg, MD. 20877

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Agnes Cemetery

Date

7/24/99

20c. Location - City or Town, State

Lock Haven, PA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Approximate Interval Between Onset and Death

week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. cardiac dysrhythmia

week

c. seizure disorder

YRS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35792

29d. Date signed (Month, Day, Year)

JULY, 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SWAROOP G. RAO; 50, W. EDMONSTON DR, ROCKVILLE, MD

31. Date filed (Month, Day, Year)

JUL 22 1999

32. Registrar's Signature

B. Smith

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24405

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph C. Rogers | | | | 2. Date of Death Month Day Year July 19, 1999 | | 3. Time of Death 5:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) 13622 Autumn Trail Drive | | | | 4b. City, Town, or Location of Death Germantown | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 141-30-8165 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) May 4, 1939 | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State New Jersey | | 10b. County Camden | | 10c. City, Town or Location Cherry Hill | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 637 Third Avenue | | 10f. Zip Code 08002 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter | | 16b. Kind of Business/Industry Self Employed | | | |
| | 17. Father's Name (First, Middle, Last) Joseph F. Rogers | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine C. Leonard | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Maureen Linstrom (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13622 Autumn Trail Drive, Germantown, MD 20874 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Date 7-22-99 | | 20d. Location - City or Town, State Beltsville, Maryland | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility The Stephenson-Brown Funeral Home 33 W Maple Avenue, Merchantville, NJ 08109 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): BONE MARROW APLASIA b. Due to (or as a consequence of): c. ACUTE MYELOGENOUS LEUKEMIA Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) daughter's residence | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number DC11241 | | 29d. Date signed (Month, Day, Year) JULY 21, 1999 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERALDINE P. SCHECHTER, M.D. VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422 | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 22 1999 | | | | 32. Registrar's Signature | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24406

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Yetta B. Rosendorf

2. Date of Death

Month Day Year
July 20, 1999

3. Time of Death

1:47 P.M.

4a. Facility Name (If not institution, give street and number)

Manorcare - Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-54-0114

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 25, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10714 Potomac Tennis Lane

10f. Zip Code

20854

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 Years

Collage (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Boris Brill

18. Mother's Name (First, Middle, Maiden Surname)

Miriam (Unascertainable)

19a. Informant's Name/Relationship (Type, Print)

Barbara Greenebaum-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6121 Shady Oak Lane, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

B'Nai Israel Congregation

Date

7/23/99

20c. Location - City or Town, State

Oxon Hill, Maryland

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

Edward Sagel Funeral Direction
1091 Rockville Pike, Rockville, Maryland 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. STROKE

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

H51280

29d. Date signed (Month, Day, Year)

07-21-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUSM DAKAR 13219 Executive Park Terrace, Germantown, MD 20874

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

Diana B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

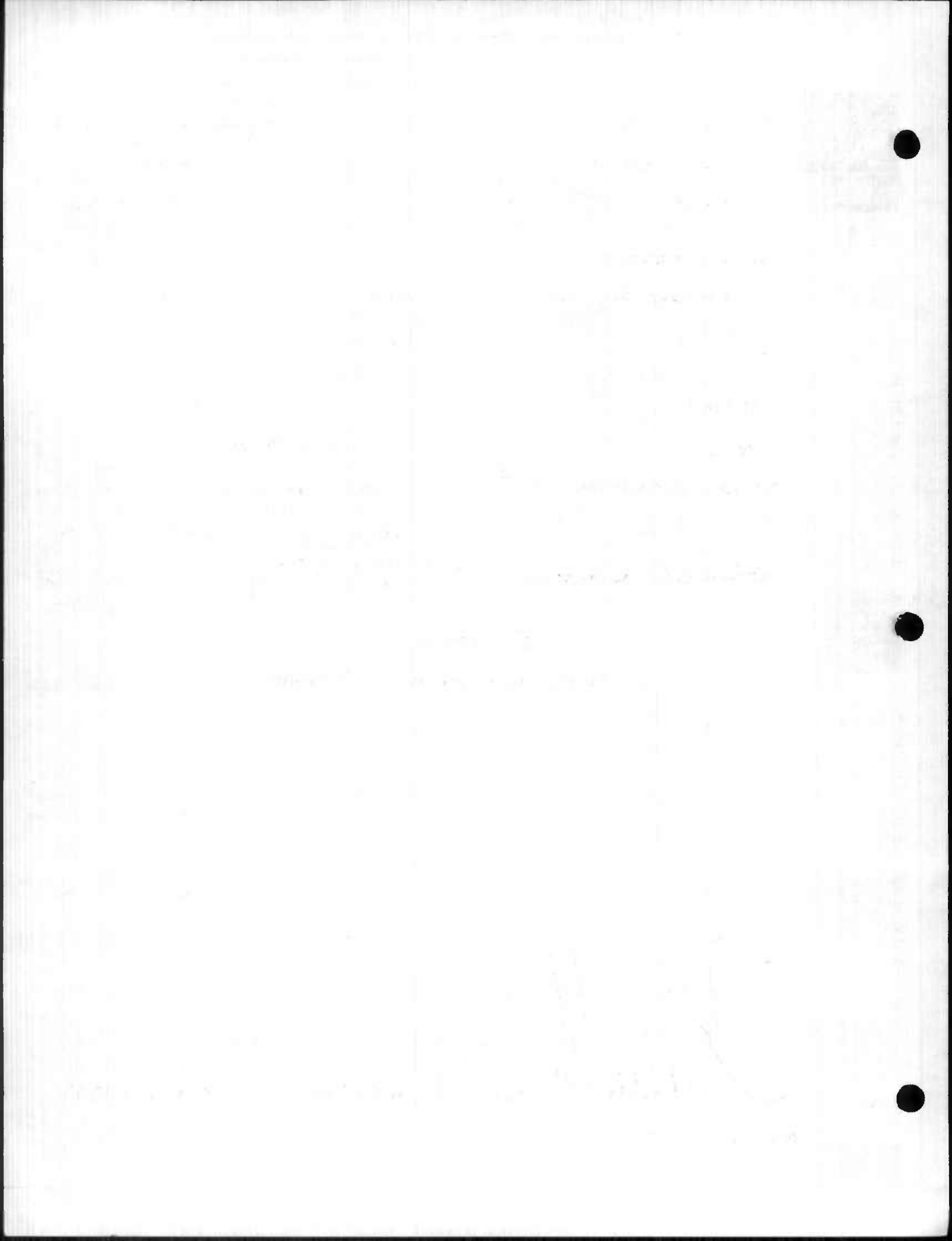
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24407

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gladys M. Sprinkle | | | | 2. Date of Death Month Day Year July 14, 1999 | | | | 3. Time of Death 12:00PM. | | | |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | | | 4c. County of Death Montgomery | | | |
| Funeral Director | 5. Social Security Number 579-12-8495 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 10, 1917 | | 9. Birthplace (State or Foreign Country) Michigan | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County Montgomery | | 10c. City, Town or Location Kensington | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 3403 Saul Road | | | | 10f. Zip Code 20895 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Director of Over Sixty Counsel Over sixty employment svc | | | | 16b. Kind of Business/Industry Employment Svcs. | | | | | |
| | 17. Father's Name (First, Middle, Last) William A. Miller | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lucetta Canby | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Kenneth S. Sprinkle - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Hidden Hill Lane Potomac, Md. 20854 | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rosedale Cemetery | | Date 7/19/99 | | 20c. Location - City or Town, State Martinsburg, WVA | | | | | |
| | 21. Signature of Funeral Service Licensee Thomas E. Hornbaker | | | | 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wi. Ave. NW. Washington, DC. 20016 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest (Asystole) Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier B.W. Leonard, MD. | | | | 29c. License number D54776 | | 29d. Date signed (Month, Day, Year) 07/16/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B.W. Leonard, MD. 8600 Old Georgetown Rd. (E.R.) Bethesda, Md. 20814 | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 23 1999 | | | | 32. Registrar's Signature Bruce G. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

24408

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24409

| | | | | | | | | |
|---|--|--|---|---|--|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edith G. Sparrow | | | | 2. Date of Death Month 7 Day 4 Year 1999 | | 3. Time of Death 3:50 am | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 216-22-3576 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 103 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) FEB. 29 1896 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 1819 Johnson Rd. | | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? US | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd. College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | 16b. Kind of Business/Industry Home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) John T. Gross Jr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Julia A. Duke | | | |
| | 19a. Informant's Name/Relationship (Type, Print) James Carter (Great Nephew) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1819 Johnson Rd. Annapolis, Md. 21401 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Annapolis Neck | | Date 7-8-99 | | 20c. Location - City or Town, State Annapolis, Md | |
| | 21. Signature of Funeral Service Licensee Harry D. Reese | | 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PNEUMONIA Due to (or as a consequence of): b. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 5 DAYS YEARS YEARS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BREAST CANCER | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier [Signature] | | | | 29c. License number MD - D39037 | | 29d. Date signed (Month, Day, Year) 7/5/99 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOUGLAS S MITCHELL, ANNE ARUNDEL MEDICAL CENTER, ANNAPOLIS MD | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 09 1999 | | 32. Registrar's Signature [Signature] | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1000 80 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24410

Amend #26, 7/19/99, BMW, Montg. Co.

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|--|---|--|---|--|--|--------------------------------|---|--|--|--|--------------------------------------|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDNA F. SWEENEY | | | | 2. Date of Death Month Day Year JULY 13 1999 | | 3. Time of Death 8:45AM | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number) SACRED HEART HOME, INC. | | | | 4b. City, Town, or Location of Death HYATTSVILLE | | 4c. County of Death PRINCE GEORGE'S | | | | | | | |
| Funeral Director | 5. Social Security Number 140-03-9566 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 27, 1912 | 9. Birthplace (State or Foreign Country) New Jersey | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State New Jersey | | 10b. County Hudson | | 10c. City, Town or Location Bayonne | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 325 Avenue A. | | | | 10f. Zip Code 07002 | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Dennis Murphy | | | | 18. Mother's Name (First, Middle, Maiden Surname) Stella Czerwinski | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) James P. Sweeney/ Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5623 Huntington Parkway, Bethesda, MD 20814 | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery | | Date July 17 1999 | | 20c. Location - City or Town, State North Arlington, NJ | | | | | | | |
| | 21. Signature of Funeral Service Licensee Steven D. Stord | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W., Silver Spring, MD 20901 | | | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RUPTURED ABDOMINAL AORTIC ANEURYSM Due to (or as a consequence of): b. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 60 HOURS YEARS | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Home <input type="checkbox"/> Other (Specify) | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier Marta Anne Schneider MD | | 29c. License number D26331 | | 29d. Date signed (Month, Day, Year) 7/13/99 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARTA ANNE SCHNEIDER MD 5401 MACARTHUR BLVD NW WASH DC 20016 | | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) 7 JUL 19 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | | | |

99-4122-005

JEFFREY
STERLING

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24411

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEFFREY THOMAS STERLING

2. Date of Death

Month
JULYDay
14, 1999

3. Time of Death

12:25 P.M.

4a. Facility Name (If not institution, give street and number)

6 DALMENY COURT

4b. City, Town, or Location of Death

PARKVILLE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

532-70-2385

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 18, 1956

9. Birthplace (State or Foreign Country)

Japan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6 Dalmeny Court, Apt. 301

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

METRIS

17. Father's Name (First, Middle, Last)

Norris P. Sterling, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Anne McComb

19a. Informant's Name/Relationship (Type, Print)

Patricia Anne Rushton/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

400 Hadaway Dr., Apt. 5, Chestertown, Md. 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Stonewall Memory Gardens

Data

20c. Location - City or Town, State

Manassas, Va.

21. Signature of Funeral Service Licensed

▶ *Pety L. Pratt*

22. Name and Address of Facility

MONEY & KING VIENNA FUNERAL HOME, INC.
171 W. Maple Ave., Vienna, Va. 22180

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)a. CONTACT GUNSHOT WOUND OF HEAD

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):

d. _____

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIFFUSE PSORIASIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

7 14 99

28b. Time of Injury

11:36 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SWIMMING & SHOT SELF.

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

RESIDENCE

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

6 DALMENY CT PARKVILLE BALTIMORE MD

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Kenneth Bruckner*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARGARET A. KOBEN MD

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

▶ *James B. Sparks*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24412

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

OTTO THOMAS STEINER

2. Date of Death

July 13 1999 11:43 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

DOCTORS HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE

Funeral
Director

5. Social Security Number

099-14-2519

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 12 1917

9. Birthplace (State or Foreign Country)

CZECHOSLOVAKIA

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

LANHAM

10d. Inside City Limits

☐ Yes ☐ No

10e. Street and Number

9001 SPRING AVENUE

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4YRS

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COMPUTER PROGRAMMER

16b. Kind of Business/Industry

NASA

17. Father's Name (First, Middle, Last)

EMIL STEINER

18. Mother's Name (First, Middle, Maiden Surname)

AMALIA OHRENSTEIN

19a. Informant's Name/Relationship (Type, Print)

YVONNE STEINER (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9001 SPRING AVENUE, LANHAM, MD. 20706

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GEORGETOWN MED SCH. 7/13/99

Date

20c. Location - City or Town, State

WASH, D.C.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

AUSTIN ROYSTER FUNERAL HOME
3821 14TH ST. N.W., WASH, DC. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration

Due to (or as a consequence of):

b. Acute myocardial infarction

Due to (or as a consequence of):

7 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D31089

29d. Date signed (Month, Day, Year)

7-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORRIS FUTCOVICH, 8201 Corporate Drive, Suite 620, LANDOVER, MD 20785

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

18

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1941

1941

1941

1941

1941

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #23b & 29c, 7/21/99, BMW, Montgomery County **Certificate of Death**

Reg. No.

99 24413

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Frank Stevens Jr.

2. Date of Death

Month Day Year
July 15, 1999

3. Time of Death

4:35pm

4a. Facility Name (If not institution, give street and number)

10401 Grosvenor Place #328

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

200-28-8191

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 17, 1939

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10401 Grosvenor Place #328

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)
12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laboratory Technician

16b. Kind of Business/Industry

NIH, NIAMS

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Julia H Doherty/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11823 Breton Court #22c Reston, VA 20191

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

July 16 1999

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Steven D Strand

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Infection of the prostate

Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Infection of prostate

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David L. Gardner

29c. License number

D-0026557 *DC #11742*

29d. Date signed (Month, Day, Year)

July 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David L. Gardner, MD 2015 R ST NW Suite 101, Washington, DC 20009 (202)265-9399

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

Renata B. Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24414

Amend #4a, 7/20/99, BMW, Montg. Co.

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|--|--|---|--|-----------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT SOODAK | | | | | 2. Date of Death Month Day Year JULY 12, 1999 | | | 3. Time of Death 10:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL - TCU | | | | | 4b. City, Town, or Location of Death OLNEY | | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 067.18.4758 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 27, 1924 | | 9. Birthplace (State or Foreign Country) NEW YORK | |
| | Usual Residence of Decedent | | | | | 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location SILVER SPRING |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3310 NORTH LEISURE WORLD BLVD. #519 | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RADIO PRODUCER | | | 16b. Kind of Business/Industry VOICE OF AMERICA | | | | | |
| 17. Father's Name (First, Middle, Last) SAMUEL SOODAK | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ROSIE ABRAMOWITZ | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROSE SOODAK/WIFE | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 N. LEISURE WORLD BLVD #519, SILVER SPRING, MD 20906 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GARDENS | | Date 7.15.1999 | | 20c. Location - City or Town, State OLNEY, MARYLAND | | | | |
| 21. Signature of Funeral Service Licensee <i>Donald C. Stottmeyer</i> | | | | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hemorrhagic Stroke Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 3 weeks unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Bennett Morrison MD</i> | | 29c. License number D 47682 | | 29d. Date signed (Month, Day, Year) July 12, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bennett Morrison 2901 Olney - Sandy Spring Road, Olney, Maryland, 20832 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature <i>Beverly B. Sparks</i> | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24415

| | | | | | | | | | | |
|---|---|---|--|-------------------------------|---|--|--|-----------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Garnett Smith, Sr. | | | | 2. Date of Death Month Day Year July 17, 1999 | | | | 3. Time of Death 8:10am | |
| | 4a. Facility Name (If not institution, give street and number) VAMHCS Fort Howard Division | | | | 4b. City, Town, or Location of Death Fort Howard | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 228-05-9426 | | 6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 14, 1906 | | 9. Birthplace (State or Foreign Country) Georgia | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County | | 10e. Street and Number 3620 Elmley Avenue | | | | 10f. Zip Code 21213 | |
| | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaper | | 16b. Kind of Business/Industry Lawn Care | | | | | |
| | 17. Father's Name (First, Middle, Last) Robert Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lizzie Wilkins | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Brenda Potter - Granddaughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 South 7th St. Newark, NJ 07107 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery | | 20c. Location - City or Town, State Farmville, Virginia | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Heart Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death Years | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Peripheral Vascular Disease | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number DS7235 | | 29d. Date signed (Month, Day, Year) July 17, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Shandelya, MD 9600 North Point Road, Fort Howard, MD 21052 | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 19 1999 | | | | 32. Registrar's Signature | | | | | |

1917

1917

1917

1917

1917

1917

1917

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24416

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES DOUGLAS SHORT

2. Date of Death

Month

Day

3. Time of Death

Year

12⁴⁵ AM

4a. Facility Name (If not institution, give street and number)

WOODSIDE CTR-GENESIS ELDERCARE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577544188

6. Sex

1^{AM} 2^F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

01

10

41

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Montgomery

Silver Spring

1^{Yes} 2^{No}

10e. Street and Number

3238 Hewitt Avenue #37

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1^{Never Married} 2^{Married}3^{Widowed} 4^{Divorced}

12. Was Decedent Ever in U.S.

Armed Forces?

1^{Yes} 2^{No}

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1^{Yes} 2^{No} Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Bernard Short

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Matilda Collins

19a. Informant's Name/Relationship (Type, Print)

Vera Lowery/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

421 West 162 Street #5E, New York, NY 10032

20a. Method of Disposition

1^{Burial} 2^{Cremation} 3^{Removal from State}4^{Donation} 5^{Other (Specify)}

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

July 22

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

James J. Collins

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Squamous cell cancer of tongue

Due to (or as a consequence of):

Sudden

b. Metastatic cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Candida esophagitis

23b. Did tobacco use contribute to the cause of death?

1^{Yes} 2^{No} 3^{Probably} 4^{Unknown}

24a. Was an autopsy performed?

1^{Yes} 2^{No}

24b. Were autopsy findings available prior to completion of cause of death?

1^{Yes} 2^{No}

25. Was case referred to medical examiner?

1^{Yes} 2^{No}

26. Place of Death (Check only one)

Hospital:

1^{Inpatient} 2^{ER/Outpatient} 3^{DOA}

Other:

4^{Nursing Home} 5^{Residence} 6^{Other (Specify)}

27. Manner of Death

1^{Natural} 5^{Pending Investigation}2^{Accident} 6^{Could not be determined}3^{Suicide} 4^{Homicide}

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1^{Yes} 2^{No}

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1^{Certifying Physician}: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2^{Medical Examiner}: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Suresh Kumar Gupta

29c. License number

D32332

29d. Date signed (Month, Day, Year)

July 22, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Suresh Kumar Gupta, MD 9801 Georgia Ave, #220 Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

B. Sparks

State Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24417

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Hilda Annette Shank | | | | 2. Date of Death Month Day Year July 17, 1999 | | 3. Time of Death 7:15A. | |
| | 4a. Facility Name (If not institution, give street and number) 4502 Josephine Avenue | | | | 4b. City, Town, or Location of Death Beltsville | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 213-24-4147 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 30, 1912 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Beltsville | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number 4502 Josephine Avenue | | | | 10f. Zip Code 20705 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry own home | |
| 17. Father's Name (First, Middle, Last) William Bean | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen C. Cuff | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Helen Alice Griffin (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Location - City or Town, State 7/21/1999 Silver Spring, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Ischaemic Heart Disease | | | | | | Approximate Interval Between Onset and Death 10-10-97 |
| | | Due to (or as a consequence of): b. Peripheral Artery Disease | | | | | | 5-1-99 |
| | | Due to (or as a consequence of): c. Chronic Renal Failure | | | | | | |
| | | Due to (or as a consequence of): d. Congestive Heart Failure | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D0013668 | | 29d. Date signed (Month, Day, Year) July 19, 1999 | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Azher Hussain, M.D. 4917 Edgewood Road College Park, Maryland 20740 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GRACE

SHAW

2. Date of Death

Month

Day

Year

JULY 17, 1999

3. Time of Death

4:05 AM

4a. Facility Name (If not institution, give street and number)

MANOR CARE - POTOMAC

4b. City, Town, or Location of Death

POTOMAC

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

191-16-9206

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

8. Date of Birth

Month

Day

Year

9. Birthplace (State or Foreign)

JULY 25, 1923

10. Inside City Limits

1 ☒ Yes 2 ☐ No

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Street and Number

10 LILY POND COURT

10e. Zip Code

20852

10f. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

NEW YORK CITY

PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

ARCHIBALD ABRAMS

18. Mother's Name (First, Middle, Maiden Surname)

HILDA KLEIN

19. Informant's Name/Relationship (Type, Print)

NANCY REINER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 LILY POND COURT - ROCKVILLE, MARYLAND 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH MOSES CEMETERY

Date

7/22/99

20c. Location - City or Town, State

PINELAWN, NEW YORK

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

DEEP VENOUS THROMBOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H51280

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANUSH DADGAR, DO 13219 EXECUTIVE PARK TERRACE GREENBELT, MD 20874

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

Beverly G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24419

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara R. Sexton

2. Date of Death
Month Day Year
July 19, 19993. Time of Death
9:15PM

4a. Facility Name (If not institution, give street and number)

7028 Heatherhill Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

303-22-8408

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

Feb. 9, 1923

9. Birthplace (State or Foreign
Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

7028 Heatherhill Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Partner

16b. Kind of Business/Industry

Engineering Consulting
Firm

17. Father's Name (First, Middle, Last)

Paul F. Royster

18. Mother's Name (First, Middle, Maiden Surname)

Nina Pease

19a. Informant's Name/Relationship (Type, Print)

Mary A. Sexton/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7028 Heatherhill Road, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)July 21, 1999
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

D. E. Perry M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave.
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cancer of Larynx

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

8 Months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Catherine A. Picken, M.D.

29c. License number

DC17380

29d. Date signed (Month, Day, Year)

7/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Catherine A. Picken, M.D. 3800 Reservoir Road, N.W., Washington, D.C. 20007-2197

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

Denise B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

James D. Smith

ADH
LUIS F. SEQUEIRA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24420

AMEND ITEM: #4C PER MD G775 9-18-99 WR.

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LUIS FERNANDO SEQUEIRA | | | | 2. Date of Death Month Day Year JULY 18, 1999 | | 3. Time of Death 1759 PM | |
| | 4a. Facility Name (If not institution, give street and number) UNIVERSITY SHOCK TRAUMA CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 577-80-7572 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 46 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 23, 1952 | |
| | 9. Birthplace (State or Foreign Country) Nicaragua | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 10017 Markham Street | | 10f. Zip Code 20901 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Nicaraguan | | |
| 14. Race - American Indian, Black, White, etc. White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician | | 16b. Kind of Business/Industry Electronics | | |
| 17. Father's Name (First, Middle, Last) Gustavo Sequeira | | 18. Mother's Name (First, Middle, Maiden Surname) Maria T. Moreno | | 19a. Informant's Name/Relationship (Type, Print) Martha Sequeira/ Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10017 Markham Street, Silver Spring, MD 20901 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Date July 24 1999 | | 20d. Location - City or Town, State Silver Spring, MD | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W., Silver Spring, MD 20901 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Multiple Gunshot Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | |
| 28a. Date of Injury (Month, Day, Year) 7-17-99 | | | | 28b. Time of Injury 745A^M | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred subject shot | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Gilmore Drive & Markham St Silver Spring, Md | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XXX | | | | 29b. Signature and title of certifier | | | | |
| 29c. License number OCME | | | | 29d. Date signed (Month, Day, Year) JULY 19, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute | | | | 31. Date filed (Month, Day, Year) JUL 22 1999 | | | | |
| 32. Registrar's Signature | | | | 33. State Registrar 10 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24421

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lila M. Schaffenburg

2. Date of Death

Day

Year

July

21, 1999

3. Time of Death

6:05 PM

4a. Facility Name (If not institution, give street and number)

Manor Care Chevy Chase

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

037-07-1311

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 17, 1915

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5480 Wisconsin Avenue #1014

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lloyd Williams

18. Mother's Name (First, Middle, Maiden Surname)

Mary Mullady

19a. Informant's Name/Relationship (Type, Print)

Dr. Carlos A. Schaffenburg/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5480 Wisconsin Ave., #1014, Chevy Chase, MD 20815

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

July 22, 1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M01126

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc., 7557 Wisconsin

Avenue, Bethesda, Maryland 20814-3501

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumonia, Bilateral*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Stroke*

Due to (or as a consequence of):

4 weeks

c. _____

Due to (or as a consequence of):

d. _____

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James J. Foster MD, 5530 Wisc. Av. Chevy Chase Md

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10 + 1

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24422

| | | | | | | | | |
|---|---|---|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALBERT CARL SCHEUNGRAB, SR. | | | | 2. Date of Death Month Day Year July 20, 1999 | | 3. Time of Death 8:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 215-12-2952 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) July 6, 1918 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location Waldorf | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 13030 Shlagel Road | | 10f. Zip Code 20601 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic | | 16b. Kind of Business/Industry Automotive | | | | |
| 17. Father's Name (First, Middle, Last) Joseph Scheungrab | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rosie Schromgurselloge | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marie A. Clark - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10557 Bramley Court, Waldorf, MD 20603 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Huntt Crematory | | Data 7-21-99 | | 20c. Location - City or Town, State Waldorf, MD | | |
| 21. Signature of Funeral Service Director <i>Mark G. Brohawn</i> Mark G. Brohawn M00053 | | 22. Name and Address of Facility Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebral Vascular Accident</i> Due to (or as a consequence of): b. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | | | | | | | | |
| Approximate Interval Between Onset and Death 5 day Year | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Dr. J. E. Feldon MD</i> | | 29c. License number 0019223 | | 29d. Date signed (Month, Day, Year) 20 July 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. E. Feldon MD Waldorf, MD 20601 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | 32. Registrar's Signature <i>B. Adams</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24423

| | | | | | | | | | | |
|--|---|---|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Harold Sprinkle, Sr. | | | | 2. Date of Death Month Day Year July 14, 1999 | | | | 3. Time of Death 10:00 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) 10618 Perkins Hill Road (Residence) | | | | 4b. City, Town, or Location of Death Chestertown | | | | 4c. County of Death Kent | |
| Funeral Director | 5. Social Security Number 236-12-7398 | | 6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) February 7, 1918 | | 9. Birthplace (State or Foreign Country) West Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Kent | | 10c. City, Town or Location Chestertown | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 10618 Perkins Hill Road | | | | 10f. Zip Code 21620 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 6 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Architect | | | | 16b. Kind of Business/Industry Building | | |
| 17. Father's Name (First, Middle, Last) John Ferdinand Sprinkle | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Cage | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jane Sprinkle/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10618 Perkins Hill Road, Chestertown, MD 21620 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Christ I.U. Cemetery | | 20c. Location - City or Town, State 7/17/99 Chestertown, Maryland | | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Pellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>COPD</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 10 yrs | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>N/A</u> | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D86054 | | 29d. Date signed (Month, Day, Year) 7/15/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICK G. STANBARD MD 120 SPEER RD Chestertown MD 21620 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 15 1999 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

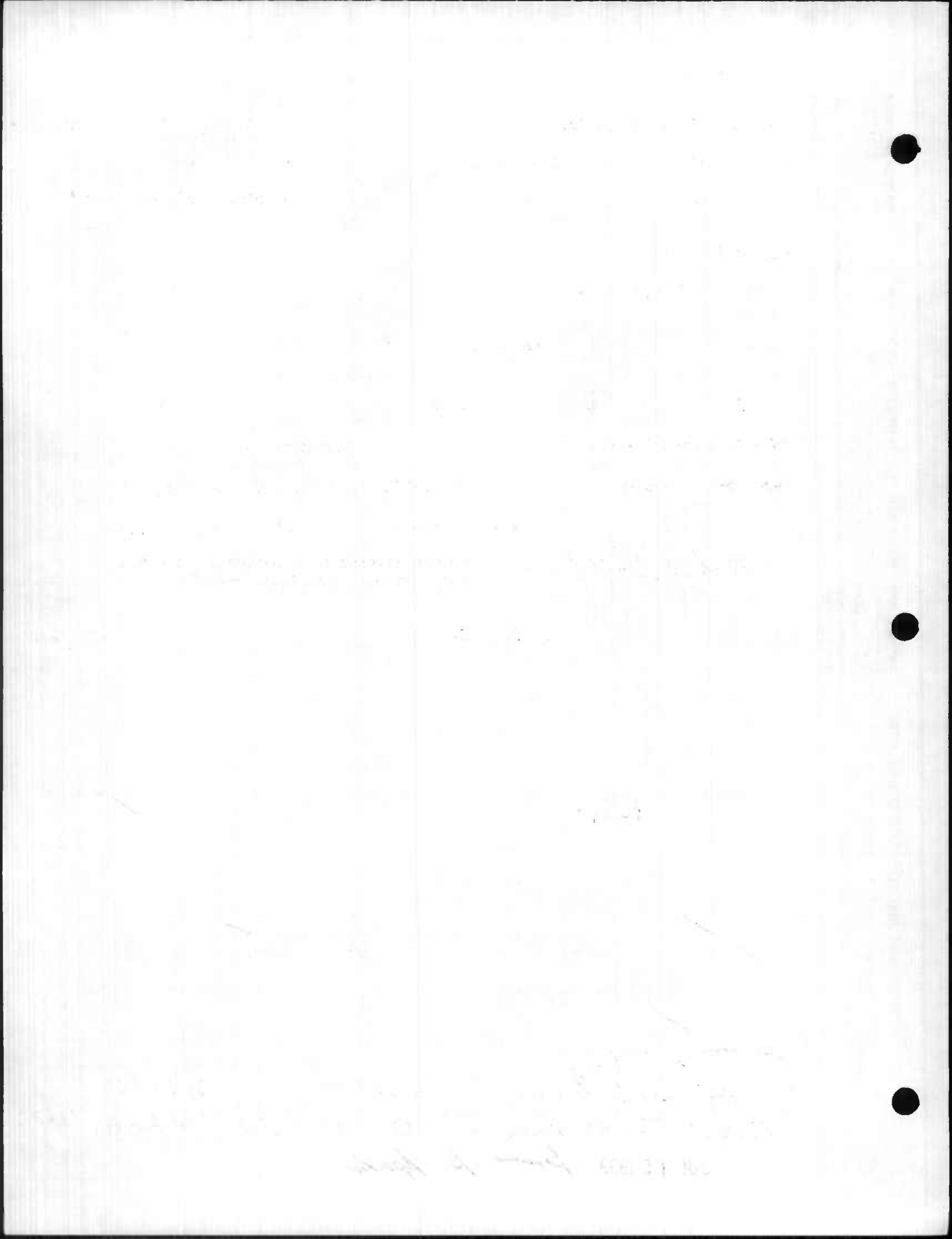
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at 6858.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clifton Izer Stanford

2. Date of Death

Month
July 21Day
1999Year
9:50PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

217-30-8109

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

11/5/35

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6805 Harmony Road

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Clifton Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Holmes

19a. Informant's Name/Relationship (Type, Print)

Dorothy Brooks/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4280 Federalsburg High. Federalsburg, MD 21632

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Federal Hill Cemetery 7/26 Federalsburg, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home
P.O. Box 43, Federalsburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic germ cell tumor

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

6 months.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis of liver

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David H. Smith

29c. License number

D39887

29d. Date signed (Month, Day, Year)

7/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

31. Date filed (Month, Day, Year)

JUL 27 1999

32. Registrar's Signature

B. Sparks

Stanford, Clifton
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24425

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL LOUIS TANGUAY

2. Date of Death

Month Day Year
JULY 17 1999

3. Time of Death

0942A

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-50-5742

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 6, 1947

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

13212 Trumpet Place

10f. Zip Code

20904

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Security Consultant

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Louis Albert Tanguay

18. Mother's Name (First, Middle, Maiden Surname)

Magdalene Spicer

19a. Informant's Name/Relationship (Type, Print)

Lori J. Tanguay (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 7/22/1999

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Pulmonary Artery Thromboembolism

Approximate
Interval Between
Onset and Death

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☒ Yes ☐ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature] M.D. (OME)

29c. License number

015236

29d. Date signed (Month, Day, Year)

JUL 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL E. MARCOW, MD, 1125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

[Signature] B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24426

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLA M. TERRY

2. Date of Death
Month Day Year
JULY 21, 19993. Time of Death
1:00 AM

4a. Facility Name (If not institution, give street and number)

6300 OSAGE ST.

4b. City, Town, or Location of Death

BERWYN HEIGHTS

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

116-03-3229

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT. 8, 1904

9. Birthplace (State or Foreign Country)

ALABAMA

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

MT. RAINIER

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3001 QUEENS CHAPEL RD. #304

10f. Zip Code

20712

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CATER/DOMESTIC ENGINEER

16b. Kind of Business/Industry

PRIVATE HOMES

17. Father's Name (First, Middle, Last)

HOMER DOZIER

18. Mother's Name (First, Middle, Maiden Surname)

LEILA TENNY THRASHER

19a. Informant's Name/Relationship (Type, Print)

STEPHANIE TERRY/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6300 OSAGE ST., BERWYN HEIGHTS, MD. 20740

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

7/23/99

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. END STAGE CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

30 DAYS

Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify)COUSINS
HOME

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D26873

29d. Date signed (Month, Day, Year)

JULY 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATHERINE SANZARO, M.D., 5804 BALTIMORE AVE., HYATTSVILLE, MD.

State
Registrar

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

(C)

000

3-20-10

000 000 000

000

000

000 000 000

000 000 000

000 000 000

000 000 000

000 000 000

000 000 000

000 000 000

000 000

000

000 000 000 000 000 000 000 000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24427

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie W. Timmerman

2. Date of Death
Month Day Year
July 22, 19993. Time of Death
2:30am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-32-7566

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 7, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11413 Ashley Drive

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Surplus Property Manager

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

James Robert Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Dora Tuck

19a. Informant's Name/Relationship (Type, Print)

John B. Timmerman / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

76 Trotters Circle, Kissimmee, FL 34743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Osceola Memory Gardens

Date

July 27 1999

20c. Location - City or Town, State

Kissimmee, FL

21. Signature of Funeral Service Licensee

James S. Ooley

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd. W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Pulmonary Emboli

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jeremy V. Cooke

29c. License number

D04602

29d. Date signed (Month, Day, Year)

July 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeremy V. Cooke, MD 10400 Connecticut Ave., Kensington, MD 20895

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

*James B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24428

Amend #26, 7/23/99, BMW, Montg. Co

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GERALD E. TREESE | | | | 2. Date of Death Month July Day 19 Year 1999 | | 3. Time of Death 0715 | |
| | 4a. Facility Name (If not institution, give street and number) 1712 BRISBANE STREET | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 209-20-5661 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 17, 1930 | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Pennsylvania | | 10b. County Montgomery | | 10c. City, Town or Location Glenside | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 543 Edgley Avenue | | | | 10f. Zip Code 19038 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Banker | | | 16b. Kind of Business/Industry Banking | |
| 17. Father's Name (First, Middle, Last) Earl Treese | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Pieghtal | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Louise Treese (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 543 Edgley Avenue Glenside, Pennsylvania 19038 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Patrick's Cemetery | | 20c. Location - City or Town, State 1999 Hockessin, Delaware | | |
| 21. Signature of Funeral Service Licensee Steen O Stroud | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) daughter's home | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Dr. Margolis | | | | 29c. License number 015236 | | 29d. Date signed (Month, Day, Year) July 19, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MARGOLIS, MD. 1125 ROCKVILLE PIKE, ROCKVILLE, MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24429

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Stanley Tretick

2. Date of Death

Month Day Year
July 19 1999

3. Time of Death

1:55 P.M.

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

578-16-1406

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
July 21, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

301 Russell Avenue

10f. Zip Code

20877

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Photographer

16b. Kind of Business/Industry

Journalism

17. Father's Name (First, Middle, Last)

William Tretick

18. Mother's Name (First, Middle, Maiden Surname)

Sophia Rosenberg

19a. Informant's Name/Relationship (Type, Print)

Kitty Kelley - Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3037 Dumbarton St. N.W. Washington, D. C. 20007

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

National Crematory

Date

7/23/99

20c. Location - City or Town, State

Falls Church, Virginia

21. Signature of Funeral Service Licensee

Thomas E. Hornbaker

22. Name and Address of Facility

Joseph Gawler's Sons

5130 Wisconsin Ave. NW Washington, D.C. 20016

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Cerebral Vascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28e. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

1960

29c. License number

D20576

29d. Date signed (Month, Day, Year)

July 20, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joel Schulman, MD 9410 Old Georgetown Road, Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly a list or table structure, but the characters are too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24430

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Marie Thompson

2. Date of Death

Month Day Year
7 14 99

3. Time of Death

6 12 PM

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

214-36-7227

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 26, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

305 Crusader Road Apt. 1

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Residence

17. Father's Name (First, Middle, Last)

Arthur Thomas Copper, Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Eva Skinner

19a. Informant's Name/Relationship (Type, Print)

Desiree Skinner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

719-Meadow Avenue Cambridge, MD, 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Paradise Cemetery

Date

7/22/99 Trappe, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

Henry Funeral Home P.A.
510 Washington St. Cambridge, MD, 21613

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Fadden

29c. License number

D26388

29d. Date signed (Month, Day, Year)

7-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Fadden MD 502 Collins Ave Annapolis MD 21403

State
Registrar

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text at the top of the page, possibly a header or title.

Handwritten text in the upper middle section of the page.

Handwritten text in the middle section of the page, appearing to be a list or series of entries.

Handwritten text in the lower middle section of the page.

Handwritten text at the bottom of the page, possibly a footer or concluding remarks.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NIKORN

VONGSOMBAT

2. Date of Death

Month

Day

Year

JULY

18,

1999

3. Time of Death

2:15 PM

4a. Facility Name (If not institution, give street and number)

10707 EDGEWOOD AVE.

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577-98-6663

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

MAR. 10, 1928

9. Birthplace (State or Foreign Country)

THAILAND

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

10707 EDGEWOOD AVE.

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

PRASAN

VONGSOMBAT

18. Mother's Name (First, Middle, Maiden Surname)

PORN

SRISOPA

19a. Informant's Name/Relationship (Type, Print)

VANNEE VONGSOMBAT/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

7/20/99

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ADENOCARCINOMA METASTATIC

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MONTH

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Brown, M.D.

29c. License number

D43496

29d. Date signed (Month, Day, Year)

7-19-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMAD A. KHALID, M.D. 8630 FENTON ST. #700, SILVER SPRING, MD. 20910

State
Registrar

31. Date filed (Month, Day, Year)

JUL 20 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND: #19b mcg 7/14/99 AACO Health

Reg. No.

99 24432

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Ivan Williams | | | | 2. Date of Death Month Day Year JULY 11 1999 | | 3. Time of Death 6:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 235-05-1532 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb 8, 1908 | |
| | Usual Residence of Decedent | | 10a. State MD | | 10b. County n/a | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3720 St. Victor Street | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chipper Caulker | | | 16b. Kind of Business/Industry U.S. Coast Guard Yard | | | |
| 17. Father's Name (First, Middle, Last) Elbert Williams | | | | 18. Mother's Name (First, Middle, Maiden Surname) Leota Dickens | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sara L. Oldroyd / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3720 St. Victor, Baltimore, MD 21225 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | Date July 14 1999 | | 20c. Location - City or Town, State Elkridge, MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier MD | | 29c. License number B45149 | | 29d. Date signed (Month, Day, Year) JULY 11 99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONABAYO 301 HOSPITAL DRIVE GLEN BURNIE MD 21061 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 14 1999 | | 32. Registrar's Signature | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

701 14 1953

99 24433

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24434

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

OSWALD T WYRICK

2. Date of Death

July 8, 1999

3. Time of Death

2:45 A.M.

4a. Facility Name (If not institution, give street and number)

2755 Riverview Drive

4b. City, Town, or Location of Death

Riva

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

228-40-7083

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 23, 1935

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Riva

10d. Inside City Limits

1□ Yes 2□ No XX

10e. Street and Number

2755 Riverview Drive

10f. Zip Code

21140

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2□ Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1□ Yes 2□ No
If Yes, Give
Year or Dates: 1955-63

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1□ Yes 2□ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Commercial Construction

17. Father's Name (First, Middle, Last)

Charles Edgar Wyrick

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Dixon

19a. Informant's Name/Relationship (Type, Print)

Patricia M. Wyrick/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2755 Riverview Drive Riva, Maryland 21140

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

7-8-99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. End stage Myelodysplasia

3 yrs

Due to (or as a consequence of):

b. Severe Pancytopenia

3 yrs

Due to (or as a consequence of):

c. Coronary Artery disease

3 yrs

Due to (or as a consequence of):

d. Chronic renal insufficiency

2 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Systemic Hypertension

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy
performed?

1□ Yes 2□ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1□ Yes 2□ No

25. Was case referred to medical

examiner?
1□ Yes 2□ No

26. Place of Death (Check only one)

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1□ Natural 5□ Pending
investigation
2□ Accident 8□ Could not be
determined
3□ Suicide
4□ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?
1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Peter Swaby

29c. License number

H0052843

29d. Date signed (Month, Day, Year)

7/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Swaby, M.D.
180 Admiral Cochrane Drive, Annapolis MD 21401State
Registrar

31. Date filed (Month, Day, Year)

JUL 09 1999

32. Registrar's Signature

B. P. Smith

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.

2000 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #31, 7/21/99, BMW, Montg. Co.

Certificate of Death

Reg. No.

24435

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Gui Ting Wang | | | | 2. Date of Death Month July Day 19 Year 1999 | | | | 3. Time of Death 11:00 AM | | | | | |
| 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Spring | | | | 4c. County of Death Montgomery | | | | | |
| 5. Social Security Number 217-51-2410 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 55 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) Oct 21, 1943 | | 9. Birthplace (State or Foreign Country) China | |
| Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 11911 Andrew St | | | | 10f. Zip Code 20902 | | | | 10g. Citizen of What Country? China | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Asian | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper | | | | 16b. Kind of Business/Industry Restaurant | | | | | |
| 17. Father's Name (First, Middle, Last) War Wang | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Wo Zhan Gou | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mei Rong Chim/Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11911 Andrew St, Silver Spring, MD 20902 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date Jul 21 | | 20c. Location - City or Town, State Silver Spring, MD | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Liver Disease Due to (or as a consequence of): Pulmonary Tuberculosis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | Approximate Interval Between Onset and Death Many weeks | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number D43496 | | 29d. Date signed (Month, Day, Year) 7-19-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8630 Penton Street Suite 700 Silver Spring MD 20910 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 | | | | 32. Registrar's Signature  | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar


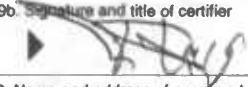
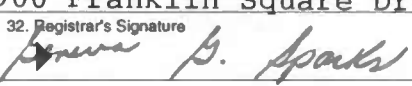
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24436

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ethel L. Watkins | | | | 2. Date of Death Month July Day 17 Year 1999 | | | | 3. Time of Death 8:50PM | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 242-48-6339 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 19, 1933 | | 9. Birthplace (State or Foreign Country) Hoffman, NC | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10e. Street and Number 6052 St. Regist RD. | | | | 10f. Zip Code 21206 | | | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | | | 16b. Kind of Business/Industry Private | |
| | 17. Father's Name (First, Middle, Last) Columbus Arron Blyther | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hattie Hart Blyther | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Lonnie Blyther/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1768 Chesaco Ave. Baltimore Md. 21237 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery | | | | 20c. Location - City or Town, State 7-23-99 Hoffman, NC | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave. NW Washington DC 20011 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. SMALL BOWEL OBSTRUCTION Due to (or as a consequence of): c. END STAGE CARDIOMYOPATHY Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 1 WEEK 1 WEEK | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL FAILURE | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospitel: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29c. License number MD 117728 | | | | | |
| | 29b. Signature and title of certifier  MD | | | | 29d. Date signed (Month, Day, Year) 07-20-99 | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ba Yin Oung 900 Franklin Square Drive Baltimore MD 21237 | | | | 31. Date filed (Month, Day, Year) JUL 22 1999 | | | | | |
| | 32. Registrar's Signature  | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24437

AMENDED ITEM #3 & #30 PER MB G774 8/24/99 AH

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|---|----|-----------------------------|--------|----|-------------------------|-------|----|--|--|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BETTY ASHBY WHITESEL | | | | 2. Date of Death Month Day Year JULY 16 1999 | | 3. Time of Death 11:45 PM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 579-26-2089 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 6. Date of Birth (Month, Day, Year) AUG. 14 1925 | 9. Birthplace (State or Foreign Country) MARYLAND | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location SILVER SPRING | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | |
| | 10e. Street and Number 13115 HATHAWAY DRIVE | | | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? UNITED STATES | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATIVE ASSISTANT | | 16b. Kind of Business/Industry EDUCATION | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) JOHN HERBERT ASHBY | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNIE RAY MENEFEE | | | | | | | | | | | | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) ROY T. WHITESEL HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13115 HATHAWAY DR. SILVER SPRING, MD. 20906 | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WARRENTON CEMETERY | | Date 7-21-99 | | 20c. Location - City or Town, State WARRENTON, VIRGINIA | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Louis L. Grant</i> | | | | 22. Name and Address of Facility HINES-RINALDI F.H. INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD. 20904 | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>ACUTE MYOCARDIAL INFARCTION</td> <td>5 DAYS</td> </tr> <tr> <td>b.</td> <td>CORONARY ARTERY DISEASE</td> <td>YEARS</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | ACUTE MYOCARDIAL INFARCTION | 5 DAYS | b. | CORONARY ARTERY DISEASE | YEARS | c. | | | d. | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | ACUTE MYOCARDIAL INFARCTION | 5 DAYS | | | | | | | | | | | | | | | | | |
| | b. | CORONARY ARTERY DISEASE | YEARS | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Samuel T. Tiscott</i> | | | | 29c. License number D005568 | | 29d. Date signed (Month, Day, Year) JULY 16, 1999 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL TISCOTT 10313 GEORGIA AVE. #307 SILVER SPRING, MD 20902 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 19 1999 | | 32. Registrar's Signature <i>Geneva B. Sparks</i> | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

24438

| | | | | | | | | |
|---|--|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Willcox, Jr. | | | | 2. Date of Death Month July Day 19 Year 1999 | | 3. Time of Death 8:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) Fox Chase Rehabilitation & Nursing Center | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 232-30-9931 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 5, 1921 | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | 10. Usual Residence of Decedent North Carolina Cumberland | | 10c. City, Town or Location Hope Mills | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1516 Abella Road | | 10f. Zip Code 28348 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1942- If Yes, Give Year or Dates: 1971 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Commissioned Officer | | 16b. Kind of Business/Industry United States Air Force | | | | |
| 17. Father's Name (First, Middle, Last) John Willcox | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mamie Gee | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Archie E. Barringer/Pastor | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2271 Jenna Shane Drive, Fayetteville, NC 28306 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lafayette Memorial Park West | | 20c. Location - City or Town, State Fayetteville, NC | | |
| 21. Signature of Funeral Service Licensee  MO0803 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Poorly Differentiated Metastatic Cancer of Unknown Origin Months Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Congestive Heart Failure Emphysema | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D42403 | | 29d. Date signed (Month, Day, Year) July 19, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raj P. Mathur, M.D., 106 Irving Street, NW, #218, Washington, D.C. 20010-2975 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

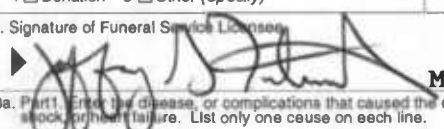
Certificate of Death

Reg. No.

99 24439

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Russell H. Williams | | | | 2. Date of Death Month July Day 19 Year 1999 | | 3. Time of Death 2:05 AM | |
| 4a. Facility Name (If not institution, give street and number) 4515 Sangamore Road, #203 | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| 5. Social Security Number 577-05-1879 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 20, 1914 | |
| 9. Birthplace (State or Foreign Country) Virginia | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Bethesda | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 4515 Sangamore Road, #203 | | | | 10f. Zip Code 20816 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Proprietor | | 16b. Kind of Business/Industry Floral Shop | |
| 17. Father's Name (First, Middle, Last) Charles Madison Williams | | | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Lacy | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert F. Cooper/Nephew | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14205 Marian Dr. Rockville, Maryland 20850 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | Date July 22, 1999 | | 20c. Location - City or Town, State Suitland, Maryland | |
| 21. Signature of Funeral Service Licensee  M00689 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic Cardiomyopathy Due to (or as a consequence of): Hypertensive Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 Years 15 Years | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus, Renal insufficiency Chronic Obstructive Lung Disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D26331 | | 29d. Date signed (Month, Day, Year) July 19, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marta Schneider, M.D. 5401 MacArthur Blvd., N.W. Washington, D.C. 20016 | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 20 1999 | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2011

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24440

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WINIFRED WOODBINE

2. Date of Death

Month
JULYDay
19,Year
1999

3. Time of Death

8:55 P.M.

4a. Facility Name (If not institution, give street and number)

Fairland Adventist Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

212-96-2595

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
May 26, 1904

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8605 Carroll Ave

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Tailoring

17. Father's Name (First, Middle, Last)

John Woodbine

18. Mother's Name (First, Middle, Maiden Surname)

Olivia Hall

19a. Informant's Name/Relationship (Type, Print)

Hope Cameron/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8605 Carroll Ave, Silver Spring, MD 20903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Jul 26

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

▶ *Olney Danell*

22. Name and Address of Facility Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cerebrovascular Accident*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *Andrew Kundra MD*

29c. License number

036716

29d. Date signed (Month, Day, Year)

July 20th, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Kundra 8317 Cherry Ln, Laurel, MD 20707

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

*Barbara B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Irvin Elmer Wagner

2. Date of Death
Month Day Year
July 23, 19993. Time of Death
11:25 AM

4a. Facility Name (If not Institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

202-20-9583

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

October 7, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9984 Reed Road

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Caucasian15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Henry Charles Wagner

18. Mother's Name (First, Middle, Maiden Surname)

Mattie King

19a. Informant's Name/Relationship (Type, Print)

Elisabeth Wagner

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9984 Reed Road, Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Mechanics Grove Church of
the Brethren Cemetery

Date

7/28

20c. Location - City or Town, State

Quarryville, Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. atherosclerotic heart disease

Due to (or as a consequence of):

years

b. dilated cardiomyopathy

Due to (or as a consequence of):

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

prostate cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D46020

29d. Date signed (Month, Day, Year)

7/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed I. Ali, M.D., 506 Idlewild Avenue, Easton, Maryland 21601

31. Date filed (Month, Day, Year)

JUL 27 1999

32. Registrar's Signature

State
Registrar

IRVIN ELMER WAGNER

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24442

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|--|---|-------------------------------|---|--|--|--|--|--|--|--|-------------------------------|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard R Ashbrook | | | | 2. Date of Death Month Day Year 08 02 99 | | 3. Time of Death 1042AM | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore City | | | | | | | |
| Funeral Director | 5. Social Security Number 236-48-6271 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) SEP. 14, 1933 | | 9. Birthplace (State or Foreign Country) Virginia | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 235 S. Gilmore Street | | | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipe Fitter | | | 16b. Kind of Business/Industry Industrial | | | | | | |
| | 17. Father's Name (First, Middle, Last) Leman Ashbrook | | | | 18. Mother's Name (First, Middle, Maiden Surname) Pansy Woodall | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) Betty E. Ashbrook - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 S. Gilmore St., Balto., Md. 21223 | | | | | | | | | |
| | 20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Crm. | | Date 8/03/99 | | 20c. Location - City or Town, State Laurel, Md. | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Fibrillation Due to (or as a consequence of): b. Cardiogenic Shock Due to (or as a consequence of): c. Multiple Organ Failure Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Respiratory Failure Coagulopathy Renal Failure | | | | | | | | Approximate Interval Between Onset and Death 15 minutes 3 days 3 days | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory Failure Coagulopathy Renal Failure | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier Torres, MD | | 29c. License number P12500 | | 29d. Date signed (Month, Day, Year) 08-02-99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugo A. Torres, MD University of Maryland Hospital | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature | | | | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24443

AMEND ITEMS: #27 PER G764 8-4-99 WR.

Certificate of Death

Reg. No.

AMON, Ruth 8540.wf
 034-03-4164 5/28/14 - 7/18/99 a20810
 Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

| | | | | | | | | | | | |
|--|---|---|---|--|---|---|---|-----------------------------------|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ruth Armon | | | | 2. Date of Death Month Day Year July 18 1999 | | | | 3. Time of Death 8:10 am | | |
| | 4a. Facility Name (If not Institution, give street and number) Atlantic General Hospital | | | | 4b. City, Town, or Location of Death Ocean City | | | | 4c. County of Death Worcester | | |
| Funeral Director | 5. Social Security Number 034-03-4164 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) May 28, 1914 | | 9. Birthplace (State or Foreign Country) Mass. | | |
| | 10e. State Maryland | | | | 10b. County Worcester | | 10c. City, Town or Location Ocean City | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10e. Street and Number 9003 Mediterranean Drive | | | | 10f. Zip Code 21842 | | | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | | 16b. Kind of Business/Industry Janitorial Service and Sales | | | | |
| | 17. Father's Name (First, Middle, Last) Louis Saltman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jenny Caplan | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) George Armon/spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9003 Mediterranean Drive, Ocean City, MD 21842 | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. renal failure Due to (or as a consequence of):</p> <p>b. sepsis Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>3 days 5 days</p> </div> </div> | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier | | 29c. License number DD053612 | | 29d. Date signed (Month, Day, Year) 7/18/99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea K Hoffman, MD, 124 N. MAIN St - Berlin, MD 21811 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24444

Amended Item#3: perPhyG774 8/4/99 FW

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ora L. Brison

2. Date of Death
Month Day Year
July 26 19993. Time of Death
7:26PM

4a. Facility Name (If not institution, give street and number)

2401 St Stephens Court

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

248-34-5412

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
1-15-1916

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2401 St Stephens Court

10f. Zip Code

21216

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Willie Byers

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Foster

19a. Informant's Name/Relationship (Type, Print)

Alaine Byers - Sister-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

500 S. Congress Street York, S.C. 29745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Woodlawn Cemetery

Date

7-31-99

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Hypertension
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Radcliffe Thomas M.D.

29c. License number

D42683

29d. Date signed (Month, Day, Year)

07/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RADCLIFFE THOMAS M.D. 4000 W Northern Pkwy
Baltimore MD 21215State
Registrar

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24445

CABO, BABYGIRL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Alison Cabo | | | | 2. Date of Death Month Day Year JUNE 26 1999 | | | | 3. Time of Death 3:32 PM | | | |
| 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death ROSEDALE | | | | 4c. County of Death BALTIMORE | | | |
| 5. Social Security Number none | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. Months Days | | 8. Date of Birth (Month, Day, Year) 05 05 June 26, 1999 | | 9. Birthplace (State or Foreign Country) MD | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State MD | | 10b. County | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 1134 Newcomb Way | | | | 10f. Zip Code 21205 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: unknown | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | | | 16b. Kind of Business/Industry | | | |
| 17. Father's Name (First, Middle, Last) Carlos Cabo | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maryra Cabo | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Maryra Cabo/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1134 Newcomb Way, Baltimore, MD 21205 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | | | Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PREMATURITY Due to (or as a consequence of): b. PRE-TERM LABOR Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 10 HOURS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Nicola London MD | | | | 29c. License number D47792 | | 29d. Date signed (Month, Day, Year) 6/26/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NICOLA LONDON MD 9000 FRANKLIN SQ. DR. BALTO, MD 21237 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24446

| | | | | | | |
|---|---|--|---|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RICHARD M. CONWAY | | 2. Date of Death Aug-2-1999 | | 3. Time of Death 11:13 AM | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 218-01-8326 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 12, 1920 |
| | 9. Birthplace (State or Foreign Country) Md. | | | | | |
| Usual Residence of Decedent | | | | | | |
| 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Towson | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number 11 Burnbrae Rd. | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW-II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Officer | | 16b. Kind of Business/Industry James Walker Co. | | |
| 17. Father's Name (First, Middle, Last) Thomas Conway | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara Gallaher | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ms. Patricia Conway/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 475 Spotsylvania, Va. 22553 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | 20c. Location - City or Town, State Towson, Md. | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Congestive Heart Failure 76mo. Due to (or as a consequence of): b. End stage Chronic Renal Failure 71yr Due to (or as a consequence of): c. Myocardial Infarction 71 years Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Sumit Mehani | | 29c. License number D44817 | | 29d. Date signed (Month, Day, Year) Aug. 03. 1999. |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sumit Mehani 2434 W Belvedere Ave, Baltimore - | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24447

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dolores C. Carouge

2. Date of Death

Month Day Year
July 31, 1999

3. Time of Death

8:00 AM

4a. Facility Name (If not institution, give street and number)

125 Orthoridge Road

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

203-22-2958

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-29-1929

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

125 Orthoridge Road

10f. Zip Code

21093

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collegiate (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas Hoover

18. Mother's Name (First, Middle, Maiden Summa)

Anna Dietrich

19a. Informant's Name/Relationship (Type, Print)

Mr. Wayne D. Carouge (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

125 Orthoridge Road, Lutherville, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gards. 8-7-99 Timonium, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Wallace S. Brubaker

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road, Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sudden Death

Due to (or as a consequence of):

b.

Scleroderma

Due to (or as a consequence of):

c.

Chronic Lung Dz re to b.

Due to (or as a consequence of):

d.

ASCVD, CHF

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard W. Hauptman, M.D.

29c. License number

D31091

29d. Date signed (Month, Day, Year)

8/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOWARD W. HAUPTMAN, M.D. 6565 N. CHARLES ST. BALTO MD 21204

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

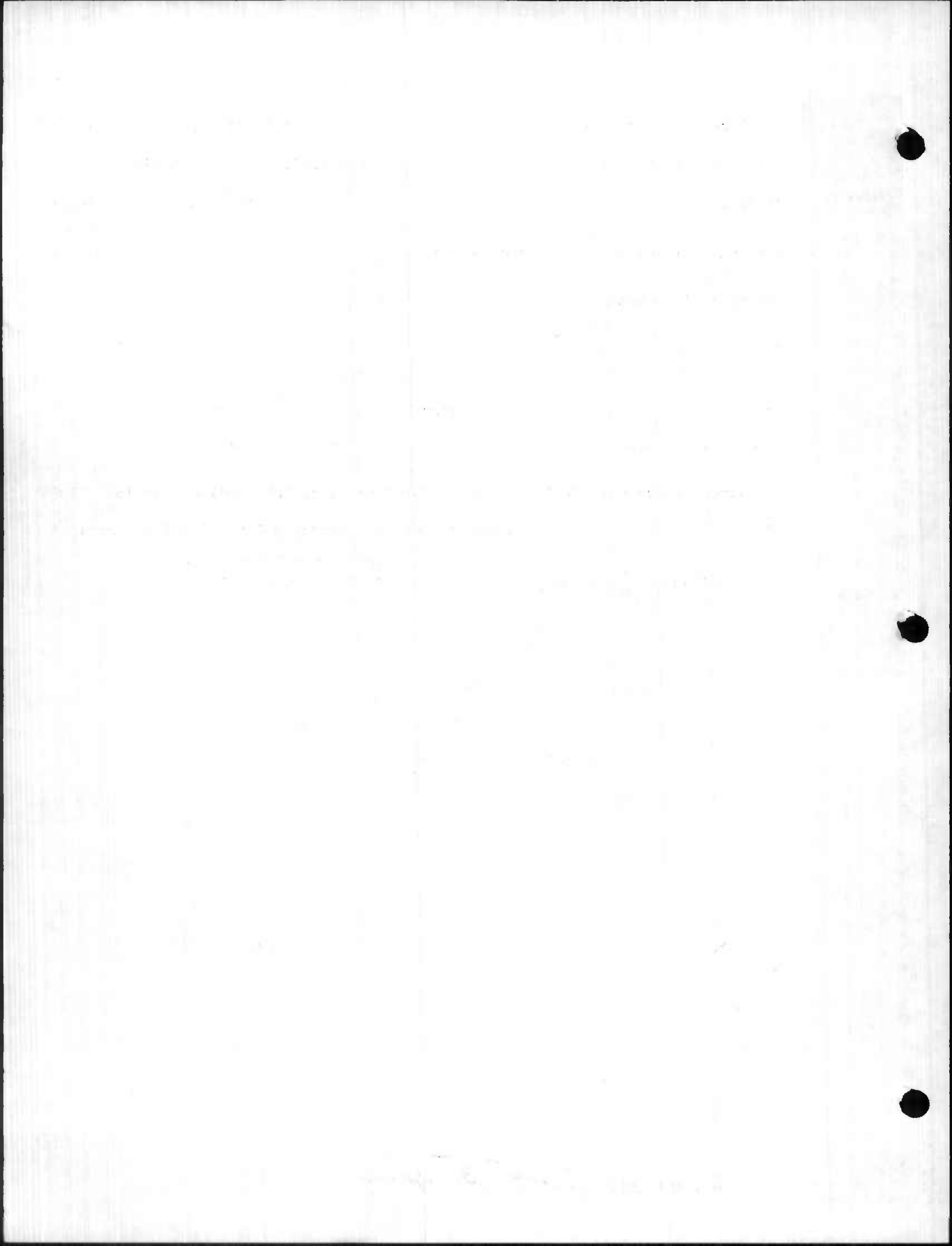
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



99-4476-043

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MD G774 8-21-99 WR.

GERALD A. DECKERT AMEND ITEMS: #23 PART I, II; 27 PER

Certificate of Death

Reg. No.

99 24448

| | | | | | | | | | | |
|---|--|--|---|--------------------------------|--|---|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gerald A. Deckert | | | | 2. Date of Death Month Day Year JULY 28, 1999 | | | | 3. Time of Death -1348-PM | |
| | 4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL | | | | 4b. City, Town, or Location of Death HAGERSTOWN | | | | 4c. County of Death WASHINGTON | |
| Funeral Director | 5. Social Security Number 215-70-3516 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAR. 3, 1953 | 9. Birthplace (State or Foreign Country) New Mexico | | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Howard | 10c. City, Town or Location Elkridge | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 6075 Claire Drive | | | | 10f. Zip Code 21075 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 6 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer | | | | 16b. Kind of Business/Industry Dept. of Defense | | | |
| | 17. Father's Name (First, Middle, Last) August Deckert | | | | 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Lennard | | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) Barbara Deckert - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6075 Claire Drive, Elkridge, Md. 21075 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Crm | | Date 8/01/99 | | 20c. Location - City or Town, State Laurel, Md. | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) JULY 30, 1999 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date (Month, Day, Year) AUG 04 1999 | | | | 32. Registrar's Signature | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

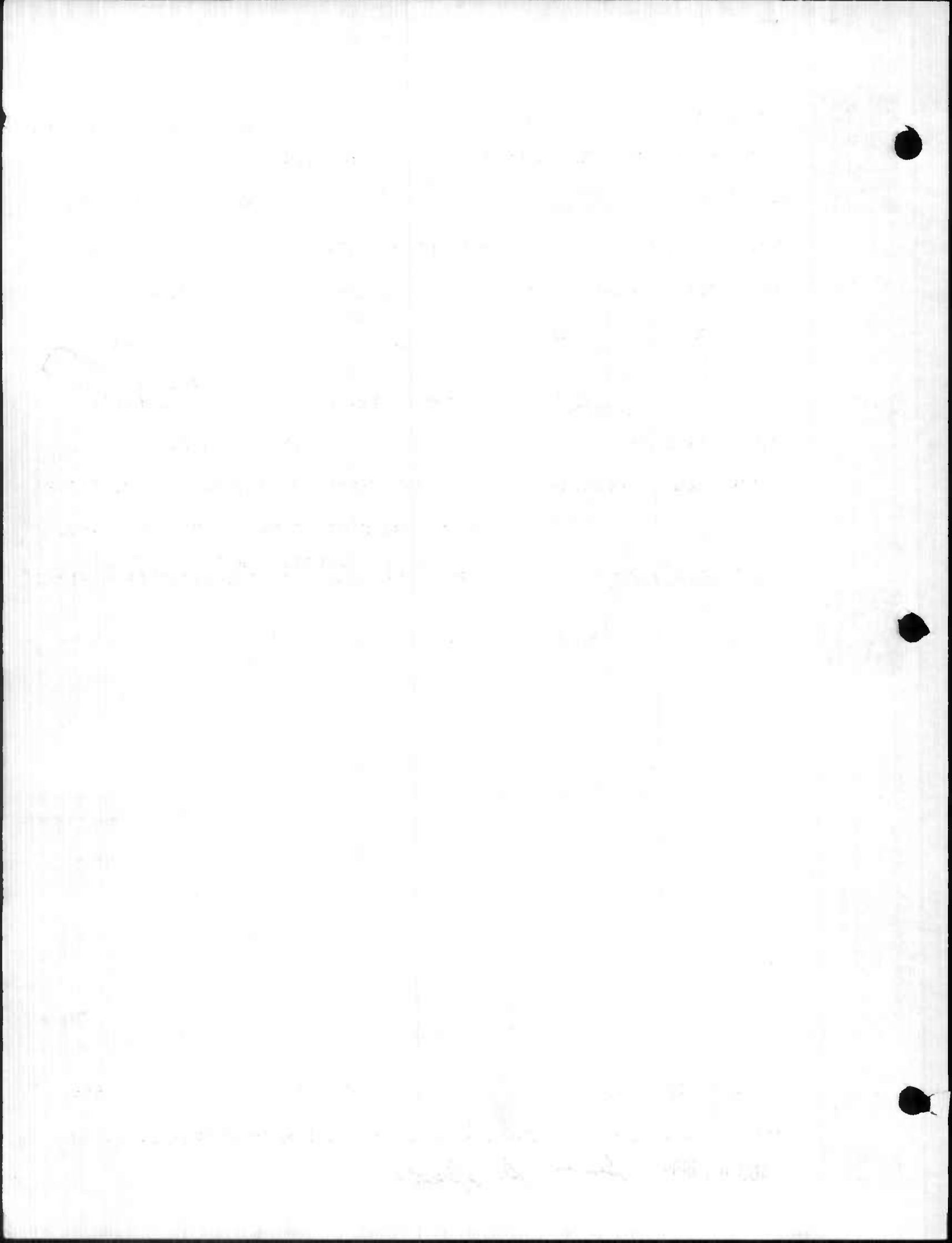
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24449

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARJORIE L. DALLAM | | | | 2. Date of Death Month JULY Day 29 Year 1999 | | 3. Time of Death 6:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 700 NORTH CHARLES STREET | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 147-16-3899 | | 6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) 08-05-1919 | |
| | 9. Birthplace (State or Foreign Country) VIRGINIA | | 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 700 NORTH CHARLES STREET | | 10f. Zip Code 21201 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) YEARS | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) VOCAL TEACHER | | | | 16b. Kind of Business/Industry VOICE TEACHER AND SOLOIST | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) OSCAR LEHMANN | | | | 18. Mother's Name (First, Middle, Maiden Surname) GLADYS FRENCH | | | |
| | 19a. Informant's Name/Relationship (Type, Print) PARKER ROUSE FREELAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 EAST EAGER ST., BALTIMORE, MD., 21202 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHURCH OF ROCK SPRINGS 8-1 | | 20c. Location - City or Town, State FOREST HILL, MD. | |
| | 21. Signature of Funeral Service Licensee R. G. Rutt | | | | 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Right Hemorrhagic Stroke Due to (or as a consequence of): b. Atherosclerotic Vascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 2 mon 10 yr | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier M. Samara, M.D. | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D 52016 | | | | 29d. Date signed (Month, Day, Year) JULY 29, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WAIEL SAMARA, M.D., 3333 N. CALVERT ST., BALTIMORE, MARYLAND, 21218 | | | | 31. Date filed (Month, Day, Year) AUG 04 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature B. Sparks | | | | | | | |
| | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24450

| | | | | | | | | |
|---|--|---|--|--|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Anne E. Dzikielewski | | | | 2. Date of Death Month Day Year JULY 29 1999 | | 3. Time of Death 1035AM | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 276-03-7016 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept 5 1911 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | 10a. State Md | | 10b. County Baltimore | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 3316 Parktowne Rd. | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | 16b. Kind of Business/Industry Maryland General Hospital | | | | |
| 17. Father's Name (First, Middle, Last) Charles P. Lutz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha E. Flickinger | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Peggy A. MacClure | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3316 Parktowne Rd. Baltimore, Md 21234 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National Ceme | | Date Aug. 2 1999 | | 20c. Location - City or Town, State Baltimore, Md | | |
| 21. Signature of Funeral Service Licensee Heidi S. Wells | | 22. Name and Address of Facility Evans Funeral Chapel 8800 Hartford Rd. Baltimore, Md 21234 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. UROSEPSIS Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death 5 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. ACUTE RENAL FAILURE Due to (or as a consequence of): | | | | | | |
| | | c. METABOLIC ACIDOSIS Due to (or as a consequence of): | | | | | | |
| | | d. DEHYDRATION | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| INSULIN DEPENDENT DIABETES MELLITUS | | | | | | | | |
| GOUT | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number P 12340 | | 29d. Date signed (Month, Day, Year) 7/29/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SINAI HOSPITAL OF BALTIMORE, 3401 W. BELVEDERE AVE, BALTIMORE, MD 21215 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

PATIENT KNOWN AS DZIKIELEWSKI, ANNE

AUG 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24451

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH PARKS DISHLER

2. Date of Death

Month August 2, Day 1999 Year

3. Time of Death

12:25 PM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

241-86-2839

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Sept. 10, Day 1947 Year

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7002 Kenleigh Rd.

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Family Therapist

16b. Kind of Business/Industry

Therapy

17. Father's Name (First, Middle, Last)

William

Brett

Parks

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca

Darnell

19a. Informant's Name/Relationship (Type, Print)

Mr. David Dishler/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7002 Kenleigh Rd. Baltimore, Md. 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

8/4/99

20c. Location - City or Town, State

Parkville, Md.

21. Signature of Funeral Director

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Breast cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

025205

29d. Date signed (Month, Day, Year)

August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley, GMC 6701 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

State Registrar

Elizabeth Dishler August 2, 1999 c 12:25 pm
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21204

AH 10

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24452

| | | | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thelma Dunbar | | | | 2. Date of Death Month Day Year July 30, 1999 | | 3. Time of Death 6:00 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center | | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince Georges | | |
| Funeral Director | 5. Social Security Number 225-24-6756 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) May 12, 1921 | | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location Capitol Heights | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 6813 Drylog Street | | 10f. Zip Code 20743 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker | | 16b. Kind of Business/Industry Own Home | | | | | |
| 17. Father's Name (First, Middle, Last) Tommie Garner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna Williamson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Leon Dunbar -Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6813 Drylog St. Capitol Heights, Maryland 20743 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Valley Mem.Pk. | | 20c. Location - City or Town, State Annandale, Va. | | 20d. Date 8/4/99 | | | |
| 21. Signature of Funeral Service Licensee Robert B. Baker Jr. | | | | 22. Name and Address of Facility Chinn Funeral Service 2605 S. Shirlington Rd. Arl., Va. 22206 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. CHF Due to (or as a consequence of): c. D-M. TYPE II Due to (or as a consequence of): d. HYPOXEMIA | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier Dr. Phil C. Baker | | | | | | | |
| 29c. License number D 27577 | | 29d. Date signed (Month, Day, Year) 8/3/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch M.D. 8614 Central Ave. Landover, Maryland 20785 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature Bruce B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24453

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--------------------------------------|--|--|---|----|---------------------------------|--------------|----------------------------------|--|--|----|--------------------------------------|--------------|----------------------------------|--|--|----|----------------------------------|--|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARIE A. FOWLER | | | | 2. Date of Death Month July Day 30 Year 1999 | | 3. Time of Death 9:30 PM | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number) CHURCH HOME HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number PIR 36-2357 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 94 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 03-19-05 | 9. Birthplace (State or Foreign Country) VA | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 1010 WILDWOOD PARKWAY | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8-TH GRADE | | College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC | | 16b. Kind of Business/Industry Home | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) JOHN JOHNSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) MAGGIE JOHNSON | | | | | | | | | | | | | | | | | | | | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) VIOLA WILSON / DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 WILDWOOD PKWY., BALTO. MD. 21229 | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | Date 8-5-99 | | 20c. Location - City or Town, State RANDALLSTOWN, MD | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Wagner C. Greene | | | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229 | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>CEREBROVASCULAR ACCIDENT</td> <td>YEARS</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>HYPERTENSIVE VASCULAR DISEASE</td> <td>YEARS</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3"></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | CEREBROVASCULAR ACCIDENT | YEARS | Due to (or as a consequence of): | | | b. | HYPERTENSIVE VASCULAR DISEASE | YEARS | Due to (or as a consequence of): | | | c. | Due to (or as a consequence of): | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | CEREBROVASCULAR ACCIDENT | YEARS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | HYPERTENSIVE VASCULAR DISEASE | YEARS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier A.P. Nazemi MD | | 29c. License number D17322 | | | | | | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) JULY 30, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMENDED ITEM #1 PER MD 8/4/99 AH

99 24454

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Fewster

2. Date of Death

Month 7

Day 31

Year 1999

3. Time of Death

4:00pm

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-20-1740

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB 20, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6401 Loch Raven Boulevard, Apt.

10f. Zip Code

527 21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Clothing Store

17. Father's Name (First, Middle, Last)

Charles Luers

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Berslicher

19a. Informant's Name/Relationship (Type, Print)

Leslie F. Fewster/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1035 Breezewick Road Towson, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 8/2/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorichik

22. Name and Address of Facility

Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. FAILURE TO THRIVE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D52228

29d. Date signed (Month, Day, Year)

8/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIPULKUMAR BHARADWAJ, 3007, E NORTHERN PKWY, BALTIMORE, MD 21214

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #23a PART I & II PER MD G774 8/4/99 AH

Certificate of Death

Reg. No.

99 24455

| | | | | | | | | |
|--|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RONALD L. FORD | | | | 2. Date of Death Month Day Year JULY 26, 1999 | | 3. Time of Death 12:45PM | |
| | 4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 213 46 2091 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 52 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug. 18, 1946 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 2423 Chesterfield Ave. | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer | | | 16b. Kind of Business/Industry Baltimore City Government | |
| 17. Father's Name (First, Middle, Last) Francis Snead Ford | | | | 18. Mother's Name (First, Middle, Maiden Surname) Muriel Clark | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Ford / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2423 Chesterfield Ave., Baltimore, MD 21213 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | Date 7/29/99 | | 20c. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee <i>Stephen D. Lohrmann</i> | | | | 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory failure</u> Due to (or as a consequence of): b. <u>Renal failure</u> Due to (or as a consequence of): c. <u>Multisystem failure</u> Due to (or as a consequence of): d. <u>HIV INFECTION</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death <u>immediate</u> <u>1 week</u> <u>4 months</u> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HIV infection</u> DIABETES MELLITUS <u>Diabetes mellitus</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Matilda H. So, MD</i> | | 29c. License number D 26250 | | 29d. Date signed (Month, Day, Year) 7/26/1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATILDA H. SO, GBMC, 6700 N. Charles St. Baltimore, MD 21204. | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature <i>James B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

[Faint handwritten signature]

DATE: _____
TIME: _____

[Faint handwritten signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24456

| | | | | | | | | | | | |
|---|--|--------------------------|---|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES R GREENE | | | | | | 2. Date of Death Month Day Year JULY 30 99 | | 3. Time of Death 16:50 | | |
| | 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Balto | | |
| Funeral Director | 5. Social Security Number 240-41-6718 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 03-27-33 | | 9. Birthplace (State or Foreign Country) NC | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 431 Notre Dame Lane | | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian | | | 16b. Kind of Business/Industry B.W.I | | | | |
| 17. Father's Name (First, Middle, Last) Edom D. Greene | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Etta Blount | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ada Terry Milado | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Long Point Chesapeake, Virginia 23322 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery | | Date 08-04-99 | | 20c. Location - City or Town, State Baltimore, MD | | | |
| 21. Signature of Funeral Service Licensee H. Valencia Holland | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NON SMALL CELL CARCINOMA Due to (or as a consequence of): b. END STAGE RENAL DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death 2 weeks | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Shirley Anderson MD | | | | 29c. License number 1) 35706 | | | |
| | | | | 29d. Date signed (Month, Day, Year) 7/30/99 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELIAS GHAN DOOR GOOD SAMARITAN HOSP. BALTO MD | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24457

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NORMAN GOSNELL | | | | 2. Date of Death Month Day Year July 31 1999 | | 3. Time of Death 2:30 AM | | |
| | 4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF OVERLEA | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 216-01-3768 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 6. Date of Birth (Month, Day, Year) APR 11, 1907 | | |
| | Usual Residence of Decedent | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 6116 Belair Road | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Greens Keeper | | 16b. Kind of Business/Industry Golf Course | | | | | |
| 17. Father's Name (First, Middle, Last) John Gosnell | | | | 18. Mother's Name (First, Middle, Maiden Surname) UNK. | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert Gosnell/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 Elm Avenue Baltimore, MD 21211 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | Date 8/2/99 | | 20c. Location - City or Town, State Baltimore, MD | | | |
| 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE MYOCARDIAL INFARCT Due to (or as a consequence of): CORONARY ARTERIOSCLEROSIS Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 1 HR. OVER 10 YEARS | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number 208344 | | 29d. Date signed (Month, Day, Year) 7/31/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 5714 HARFORD RD. BALTO. MD. 21214 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature [Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24458

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William F. Hoffman

2. Date of Death

Month Day Year
JULY 28, 1999

3. Time of Death

11:10 PM

4a. Facility Name (If not institution, give street and number)

Frederick Villa Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

215-07-1171

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB. 3, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1239 Leeds Terrace

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4or 5+)
12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Draftsman

16b. Kind of Business/Industry

Engineering

17. Father's Name (First, Middle, Last)

William F. Hoffman

18. Mother's Name (First, Middle, Maiden Surname)

Edna Miller

19a. Informant's Name/Relationship (Type, Print)

Mildred Carle Hoffman - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1239 Leeds Terrace, Balto., Md. 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

7/31/99

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Nephropathy
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Raymond Miller MD

29c. License number

D 47683

29d. Date signed (Month, Day, Year)

7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymond Miller 25 Main Street Suite 200 Reisterstown MD

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24459

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Baby boy Hnyla | | | | 2. Date of Death Month Day Year June 23 1999 | | 3. Time of Death 4:25 PM | |
| 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death BAITIMORE | |
| 5. Social Security Number none | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. Months Days 1 05 | | 8. Date of Birth (Month, Day, Year) June 23, 1999 | |
| 9. Birthplace (State or Foreign Country) MD | | | | 10. Usual Residence of Decedent | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 915 Spangler Way | | | | 10f. Zip Code 21205 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) None | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | 16b. Kind of Business/Industry | |
| 17. Father's Name (First, Middle, Last) Carl Edward Hall | | | | 18. Mother's Name (First, Middle, Maiden Surname) Stephanie Hnyla | | | |
| 19a. Informant's Name/Relationship (Type, Print) Stephanie Hnyla/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Spangler Way, Baltimore, MD 21205 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy board, 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Premature Birth Due to (or as a consequence of): b. Inevitable Abortion Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death 18 weeks | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier S. Menon, M.D. | | | | 29c. License number RD 191908 | | 29d. Date signed (Month, Day, Year) June 23, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Suresh Menon 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | | 32. Registrar's Signature B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

Handwritten signature or initials at the bottom center of the page.

EGGT 20 00A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24460

| | | | | | | | | |
|---|---|--|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Ruth I. Holt</u> | | | | 2. Date of Death Month <u>July</u> Day <u>28</u> Year <u>1999</u> | | 3. Time of Death <u>5:32AM</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Milchrist Center</u> | | | | 4b. City, Town, or Location of Death <u>Towson</u> | | 4c. County of Death <u>Baltimore</u> | |
| Funeral Director | 5. Social Security Number <u>451-09-5063</u> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday) <u>83</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <u>Sept 15, 1915</u> | 9. Birthplace (State or Foreign Country) <u>Oklahoma</u> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <u>Md</u> | | 10b. County <u>Baltimore</u> | | 10c. City, Town or Location <u>Lutherville</u> | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number <u>8 Dunwich Rd.</u> | | | | 10f. Zip Code <u>21093</u> | | 10g. Citizen of What Country? <u>USA</u> | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>4</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>homemaker</u> | | 16b. Kind of Business/Industry <u>home</u> | | |
| 17. Father's Name (First, Middle, Last) <u>David H. Strawn</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Abalym Johnson</u> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Arthur L. Holt</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8 Dunwich Rd. Lutherville, Md 21093</u> | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Dulaney Valley Mem. Gdns</u> | | Date <u>July 30 1999</u> | | 20c. Location - City or Town, State <u>Timonium, Maryland</u> | | |
| 21. Signature of Funeral Service Licensee <u>Heista S. Wells</u> | | | | 22. Name and Address of Facility <u>EVANS Funeral Chapel</u> <u>2325 YORK Rd. Timonium, Md 21093</u> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. nonHodgkins lymphoma</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>b.</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u> | | | | Approximate Interval Between Onset and Death <u>2k2y3</u> | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>congestive heart failure</u> <u>large (L) pleural effusion</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <u>HOSPICE</u> | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <u>Ruth Carter MD</u> | | 29c. License number <u>D28594</u> | | 29d. Date signed (Month, Day, Year) <u>July 29, 1999</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DR. Ruth Carter MD 6569 North Charles St. Towson, Md.</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 04 1999</u> | | 32. Registrar's Signature <u>James B. Sparks</u> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24461

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Howard Howser

2. Date of Death

JULY 30, 1999

3. Time of Death

11:25 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-28-6190

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 13, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

59 Belmore Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

Bell Atlantic

17. Father's Name (First, Middle, Last)

Charles E. Howser

18. Mother's Name (First, Middle, Maiden Surname)

Ida N. Bright

19a. Informant's Name/Relationship (Type, Print)

Anna Marie Howser

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

59 Belmore Rd Lutherville, Md 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Mem Gdns

Date

Aug 3 1999

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

EVANS Funeral Chapel
8800 Harford Rd. Baltimore, Md 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

ACUTE RENAL FAILURE

e.

Due to (or as a consequence of):

ACUTE TUBULAR NECROSIS

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
interval Between
Onset and Death

10 DAYS

10 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

ANOXIC ENCEPHALOPATHY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis Khoo

29c. License number

D 30263

29d. Date signed (Month, Day, Year)

08-01-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State
Registrar

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

Francis B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24462

| | | | | | | | | |
|---|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James H. Howe | | | | 2. Date of Death Month Day Year JULY 31, 1999 | | 3. Time of Death 1357 PM | |
| | 4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 213-66-7331 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 43 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 12, 1956 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Elkridge | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 5678 Furnace Avenue | | | | 10f. Zip Code 21075 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman | | | 16b. Kind of Business/Industry Construction | |
| 17. Father's Name (First, Middle, Last) Frank Howe | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Coyle | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Elizabeth A. Howe (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 S. Baylis Street, Baltimore, Maryland 21224 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Gard. | | 20c. Location - City or Town, State Baltimore, Maryland | | Date 8/4/99 |
| 21. Signature of Funeral Service Licensee John W. Burkowski | | | | 22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chest Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7/31/99 | | 28b. Time of Injury 1309 M | | 28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred Subject crushed between front loader and dumpster |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Business | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5673 Furnace Ave 21075 | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. James H. Howe MD | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUG. 1, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. LARON Locke MD | | | | 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature G. Sparks | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24463

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles E. Jackson

2. Date of Death

July 30 1999

3. Time of Death

545 AM

4a. Facility Name (If not institution, give street and number)

Liberty Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

215-14-5444

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 28, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3212 Mondawmin Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 3/43-3/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
unknown

College (1-4 or 5+)
unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

City Government

17. Father's Name (First, Middle, Last)

Nathaniel Charles Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Elizabeth Curry

19a. Informant's Name/Relationship (Type, Print)

Margaret Jackson/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3212 Mondawmin Avenue, Baltimore, MD 21216

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Probable acute Myocardial Infarction

Due to (or as a consequence of):

Hypertensive and arteriosclerotic

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Resected Lung Carcinoma
chronic obstructive Pulmonary
Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Rafat Abouyimo

29c. License number

D2729

29d. Date signed (Month, Day, Year)

July 31, 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 Garrison Blvd Suite MD 21216

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24464

| | | | | | | | | |
|--|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHNNIE MAE JONES | | | | 2. Date of Death Month Day Year AUGUST 2, 1999 | | 3. Time of Death 11:15pm | |
| | 4a. Facility Name (If not institution, give street and number) 3720 ECHODALE ROAD | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 128-26-8613 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) 03-28-34 | |
| | 9. Birthplace (State or Foreign Country) ANDERSON, SC | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3720 ECHODALE ROAD | | 10f. Zip Code 21206 | | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED | | 16b. Kind of Business/Industry SEAMTRESS | | |
| 17. Father's Name (First, Middle, Last) UNKNOWN | | | | 18. Mother's Name (First, Middle, Maiden Surname) GRACIE SLOAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print) SHERITA & KEITH PENLAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3720 ECHODALE RD, BALTIMORE, MD 21206 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY | | 20c. Date 8-7-99 | | 20d. Location - City or Town, State OWINGSMILLS, MD | | |
| 21. Signature of Funeral Service Licensee <i>Willie Edmundo</i> | | 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HIGHTS AVE, BALTO. MD 21207 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 2 1/3 years | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Paul Hing no</i> | | 29c. License number D40854 | | 29d. Date signed (Month, Day, Year) 8/4/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Ruseberg 301 St Paul Pl Baltimore, MD 21202 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature <i>Beverly G. Sparks</i> | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24465

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Philip Allen Johnson

2. Date of Death

Month Day Year
AUG 2, 1999

3. Time of Death

1:15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

201-09-9978

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUN 16, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23 Tintern Court #202

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1944-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Head of Purchasing

16b. Kind of Business/Industry

Martin Marietta
Aerospace

17. Father's Name (First, Middle, Last)

Emil Leonard Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Jesse Lillian Reynolds

19a. Informant's Name/Relationship (Type, Print)

Karen L. Johnson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6115 Twilight Court Rosedale, MD 21206

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 8/3/99 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward A. Gregorich

22. Name and Address of Facility

Cremation Society of MD, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. renal cancer

Approximate Interval Between Onset and Death

4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Anthony Riley, MD

29c. License number

D25285

29d. Date signed (Month, Day, Year)

August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley 6801 N. Charles St. Balt. md 21206

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

B. Sparks

State
Registrar

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

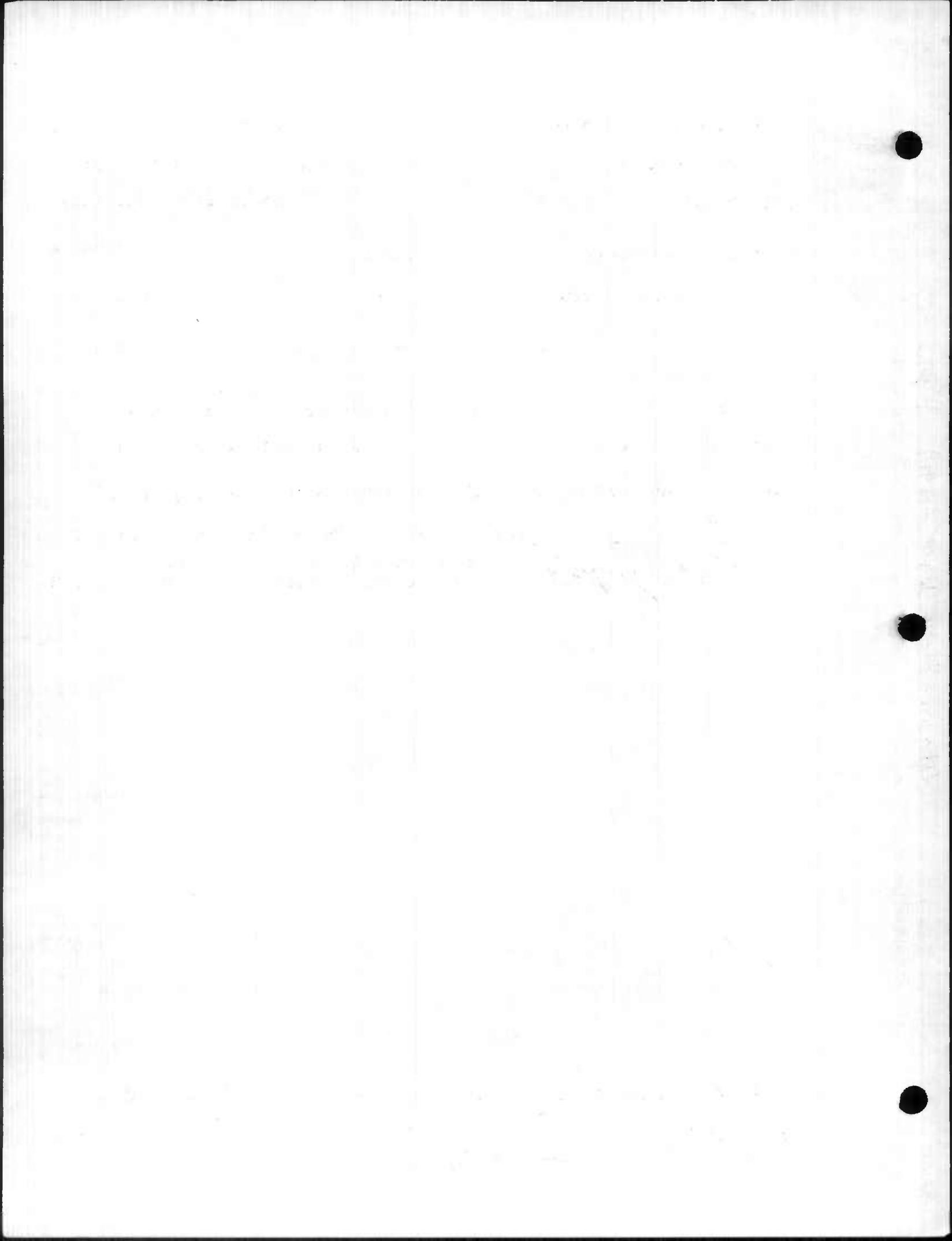
Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24466

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER RAYMOND JASPER

2. Date of Death

Month Day Year
JULY 28, 1999

3. Time of Death

6:50 P.M.

4a. Facility Name (If not institution, give street and number)

FALTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALTON

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

212-26-1908

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 24, 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

ABINGDON

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1413 MYLAOYS DRIVE

10f. Zip Code

21009

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

INSPECTOR

16b. Kind of Business/Industry

GENERAL MOTORS

17. Father's Name (First, Middle, Last)

LOUIS JASPER

18. Mother's Name (First, Middle, Maiden Summa)

LORETTA HISKY

19a. Informant's Name/Relationship (Type, Print)

NARGARET M. JASPER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1413 MYLAOYS DRIVE ABINGDON, MARYLAND 21009

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOVON PARK

Date

AUG. 2 1999

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS FUNERAL CHAPEL - BELAIR, P.A. 21050
3 NEWPORT DRIVE FOREST HILL, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Non Small Cell Lung Cancer

Approximate Interval Between Onset and Death

101 months

Due to (or as a consequence of):

b. Radiation Pneumonitis

2 months

Due to (or as a consequence of):

c. Clostridium Difficile Colitis

2 Weeks

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

[Signature]

29c. License number

D45530

29d. Date signed (Month, Day, Year)

JULY 28, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Sirasailam, Md. 6830 Hospital Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24467

August 2, 1999 7:10 p.m.

Baltimore, Maryland 21215-0020

Lennell Jackson

Division of Vital Records, P.O. Box 68760,

AH5+1

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Lennell Jackson | | | | | | 2. Date of Death Month Day Year August 2 1999 | | 3. Time of Death 7:10 PM | |
| 4a. Facility Name (If not institution, give street and number) Stella Maris, 7300 Dulaney Valley Rd. | | | | | | 4b. City, Town, or Location of Death Timonium MD, Baltimore | | 4c. County of Death | |
| 5. Social Security Number 094-60-6008 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 37 Yrs | | 8. Date of Birth (Month, Day, Year) Oct 20, 1961 | | 9. Birthplace (State or Foreign Country) New York | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 6503 Laurelton Ave. | | | | 10f. Zip Code 21214 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates Feb 15, 1980 April 1, 1983 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacist | | | 16b. Kind of Business/Industry Medicine | | |
| 17. Father's Name (First, Middle, Last) Joseph Hailey | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Watson | | | |
| 19a. Informant's Name/Relationship (Type, Print) Paulette Lopez - sister | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6503 Laurelton Ave, Baltimore, MD, 21214 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest | | 20c. Location - City or Town, State August 6, 1999 Owings Mills, MD. | | | | | |
| 21. Signature of Funeral Service Licensee Carlton C. Douglas | | | | | | 22. Name and Address of Facility Devliss Funeral Service 1701 McCulloh Street, Baltimore, MD, 21217 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Breast Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier Li 7 | | | | 29c. License number D43725 | | 29d. Date signed (Month, Day, Year) 8/3/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24468

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred H. Jenkins

2. Date of Death

Month July 31, Day 1999 Year

3. Time of Death

2:59 PM

4a. Facility Name (If not institution, give street and number)

2315 Edwards Lane

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

216 18 6756

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month March 6, Day 1923 Year

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Baltimore10c. City, Town or Location
Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

162 Orville Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Steel Mill

17. Father's Name (First, Middle, Last)

Michael Hartnett

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Sternsdorff

19a. Informant's Name/Relationship (Type, Print)

Ted M. Jenkins (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2315 Edwards Lane Bel Air, Maryland 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery 8/3/1999

Data

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 2122123a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Non small cell Lung Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 Months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)(son's
Residence)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANET COOPER MD 1447 York Rd Lutherville MD 21093

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24469

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE P. KARAGEORGOS

2. Date of Death
Month Day Year
August 3, 1999

3. Time of Death
5:55 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

160-52-2433

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 15, 1930

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1623 York Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Photographer

16b. Kind of Business/Industry

Valley Studios

17. Father's Name (First, Middle, Last)

Panagiotis

Karageorgos

18. Mother's Name (First, Middle, Maiden Surname)

Vasiliki

Karageorgos

19a. Informant's Name/Relationship (Type, Print)

Mr. Panagiotis Karageorgos/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1623 York Rd. Lutherville, Md. 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Rose Cemetery

Date

8/6/99

20c. Location - City or Town, State

York, Pa.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) HOSPICE

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

8/3/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

State
Registrar

August 3, 1999 5:55 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

George Karageorgos

Division of Vital Records, P.O. Box 68760,

A74

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

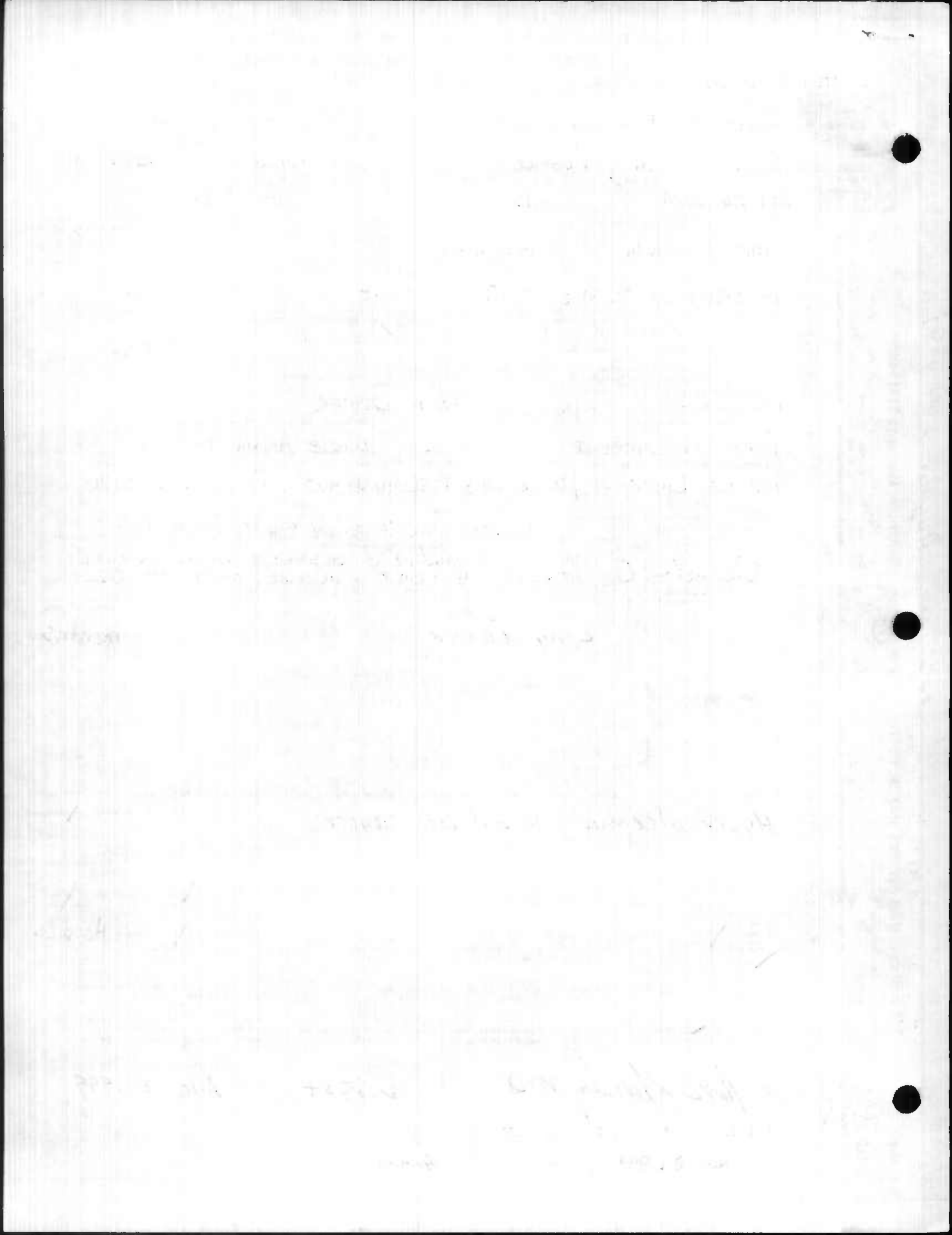
99 24470

AMEND ITEM: #30 PER V.R. G774 8-4-99 WR.

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES R. LAMBERT | | | | 2. Date of Death Month Day Year 08 - 02 - 99 | | | | 3. Time of Death 12:40 PM | |
| | 4a. Facility Name (If not institution, give street and number) JOSEPH RITCHIE HOSPICE | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 217-26-2024 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) 03-20-23 | | 9. Birthplace (State or Foreign Country) VA | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 918 BELGIUM AVENUE #18 | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH GRADE College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | | | 16b. Kind of Business/Industry | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) JAMES R. LAMBERT | | | | 18. Mother's Name (First, Middle, Maiden Surname) WILLIE ANNA MASON | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) BERNICE LAMBERT / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 BELGIUM AVE., BALTO. MD. 21218 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY | | Date 8-6-99 | | 20c. Location - City or Town, State BALTO. MD | | | |
| | 21. Signature of Funeral Service Licensee Wagner C. Greene | | | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death months | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypocalcemia, Renal cell cancer | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Paul E. Gormley MD | | | | 29c. License number D18587 | | 29d. Date signed (Month, Day, Year) AUG 2 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PAUL E. GORMLEY 900 CATON AVE. BALTIMORE, MD 21229 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 04 1999 | | | | 32. Registrar's Signature James R. Lambert | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 21171

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NECRETIA LINEBERGER

2. Date of Death

July 28, 1999

3. Time of Death

10:39A

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

226-32-2579

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

06 20 1928

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2520 Harford Road

2nd Floor

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Howard

19a. Informant's Name/Relationship (Type, Print)

LaContis Howard/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1105 E. 43rd Street, Apt 4 Baltimore, Md. 21239

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

8/3/99

20c. Location - City or Town, State

Catonsville, Md.

21. Signature of Funeral Service Licensee

Barbara A. Brown

22. Name and Address of Facility

William C. Brown Community Funeral Home

1206 W. North Avenue, Baltimore, Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Squamous Cell Carcinoma of lung 11 months

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Depression

Due to (or as a consequence of):

d. Hypercalcemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nisha Soprey M.D.

29c. License number

22 4476

29d. Date signed (Month, Day, Year)

7 30 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NISHA SOPREY, MD 2300 Gaisman Blvd Balto MD 21216

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

*B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-555-8000.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24472

| | | | | | | | | |
|--|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Anna Marguerite Lang | | | | 2. Date of Death Month July Day 31 Year 1999 | | 3. Time of Death 3:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) 216 Morris Ave. | | | | 4b. City, Town, or Location of Death Lutherville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-74-6335 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) 5-7-1912 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Lutherville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 216 Morris Ave. | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? U. S. A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) William Castleman Rose | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rose Marie Jubb | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mr. Millard T. Lang (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Morris Ave. Lutherville, Maryland 21093 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gards. 8-3-99 Timonium, Maryland | | 20c. Location - City or Town, State | | 20d. Approximate Interval Between Onset and Death | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Wallace S. Brooks | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardiovascular disease 20 yrs Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Advanced Alzheimer's dementia Cardiorespiratory arrest. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| Division of Vital Records, P.O. Box 68760, MD 21243 | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| State Registrar | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| DHHM 16 Rev 6/95 | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier M. Kaminski MD | | 29c. License number D31339 | |
| | 29d. Date signed (Month, Day, Year) 8/2/1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITCHELL KAMINSKI 6701 N. CHARLES, BALTO MD 21204 | | | | | |
| AUG 04 1999 | 31. Date filed (Month, Day, Year) | | 32. Registrar's Signature B. Sparks | | | | | |
| | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, MD 21243

AUG 04 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24473

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Brandon McFail</i> | | | | 2. Date of Death Month Day Year JULY 31, 1999 | | 3. Time of Death 0620 AM | |
| | 4a. Facility Name (If not institution, give street and number) 3500 BLOCK GWYNNS FALLS PARKWAY | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number <i>218-15-1656</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 18 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 14, 1981 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2406 Monticello Rd. | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vendor | | 16b. Kind of Business/Industry Camden Yards | | 17. Father's Name (First, Middle, Last) Larry McFail | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Cynthia Reaves | | 19a. Informant's Name/Relationship (Type, Print) Cynthia McFail-mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 Monticello Rd. Baltimore, Maryland 21216 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery | | 20c. Location - City or Town, State Landsdowne, Maryland | | 21. Signature of Funeral Service Licensee Kevin Parker | | 22. Name and Address of Facility Kevin A. Parker Funeral Home 3572 Frederick Ave. Baltimore, MD. 21229 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Stab Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Foun 7-31-99 | |
| | 28b. Time of Injury unknown M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred subject was stabbed | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) sidewalks | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier Stephen S. Radentz | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) JULY 31, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23) (Type, Print) Stephen S. Radentz | | 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature B. Sparks | | 33. Location (Street and Number or Rural Route Number, City or Town, State) 111 Penn Street, Baltimore, Maryland 21201 | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

WRC
99-4502-510

ANGELA

MURPHY

AMEND: #23 PART I, 27 28A-F PER MEO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland, Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24474

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Angela Murphy

2. Date of Death

Month Day Year
JULY 31, 1999

3. Time of Death

3:19 PM.

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

UNK

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

July 23, 1961

9. Birthplace (State or Foreign)

Country

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3907 Fairview Ave.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th Grade

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Baker

16b. Kind of Business/Industry

Hauswalds Bakery

17. Father's Name (First, Middle, Last)

Ellis Murphy

18. Mother's Name (First, Middle, Maiden Surname)

Delores Marshall

19a. Informant's Name/Relationship (Type, Print)

Delores Murphy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3907 Fairview Ave. Baltimore, Maryland 21216

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Zion Cemetery

Date

8/4

20c. Location - City or Town, State

Landsdowne, Maryland

21. Signature of Funeral Service Licensee

Kevin Parker

22. Name and Address of Facility

Kevin A. Parker Funeral Home

3572 Frederick Ave. Baltimore, MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC, ALCOHOL AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending Investigation

6 ☒ Could not be determined

28a. Date of Injury

(Month, Day Year)

UNKNOWN

28b. Time of Injury

UNKNOWN

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State)

UNKNOWN

29a. Certifier (Check only one)

1 ☐ Certifying Physician

2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUG. 01, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24475
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | |
|--|--|--|---------------------------|-----------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) James E. McArthur | | 2. Date of Death Month July Day 31 Year 1999 345 pm | | 3. Time of Death 345 pm | |
| 4a. Facility Name (If not institution, give street and number) Maryland General Hospital | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| 5. Social Security Number 245-50-6039 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 04 25 1933 |
| 9. Birthplace (State or Foreign Country) North Carolina | | | | | |

Funeral
Director

To Be Completed by Funeral Director

| | | | | | | |
|--|--|---|---|--|--|--|
| Usual Residence of Decedent | | 10a. State Maryland | | 10b. County N/A | 10c. City, Town or Location Baltimore City | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 4800 Yellowwood Avenue Apt T-05 | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Transportation | | |
| 17. Father's Name (First, Middle, Last) James Arthur, Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname) Hattie Alston | | | |
| 19e. Informant's Name/Relationship (Type, Print) Irene McArthur/Wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Yellowwood Ave, Apt T-05, Baltimore, Md. 21209 | | | |

| | | | | | |
|---|--|---|--|-----------------------|--|
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn | | Date 8/6/99 | 20c. Location - City or Town, State Woodland, Md |
| 21. Signature of Funeral Service Licensee <i>William C. Brown</i> | | 22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Md. 21217 | | | |

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

| | | |
|---|--|--|
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. left cerebral edema Due to (or as a consequence of): b. extensive infarction in distribution of left middle cerebral artery Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate interval between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | |

| | | | |
|--|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
|--|--|---|--|

| | | | |
|---|--|--|--|
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
|---|--|--|--|

| | | | | | |
|---|--|---|--|---------------------------------|---|
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | 28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |

| | | | | | |
|---|--|--|--|-------------------------------------|---|
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Anika Sarwar | | 29c. License number 89345 | 29d. Date signed (Month, Day, Year) 7-31-99 |
|---|--|--|--|-------------------------------------|---|

| | |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANIKA SARWAR BHATTI M.D. MARYLAND GENERAL HOSPITAL | |
|---|--|

| | |
|---|---|
| 31. Date filed (Month, Day, Year) AUG 04 1999 | 32. Registrar's Signature <i>Anika B. Sparks</i> |
|---|---|

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24476

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Melissa Moore

2. Date of Death

Month 8 Day 9 Year 99

3. Time of Death

7:15 AM

4a. Facility Name (If not institution, give street and number)

Ravenwood Nursing & Rehab Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-84-9962

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

26 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
03 06 1973

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street end Number

741 N. Fulton Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Never employed

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Thomas L. Moore

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Dorsey

19a. Informant's Name/Relationship (Type, Print)

Genevieve Johnson/Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

William C. Brown Community Funeral Home
1206 W. North Avenue, Baltimore, Md. 21217

20a. Method of Disposition

1 ☒ Burial ☐ Cremation ☐ Removal from State
4 ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

8/6/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

William C. Brown Community Funeral Home
1206 W. North Avenue, Baltimore, Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis of the liver

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

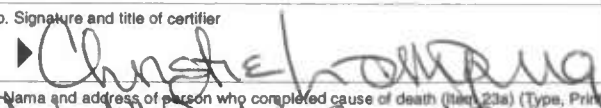
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D32263

29d. Date signed (Month, Day, Year)

8/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTINE CHAMPION 1940 West Baltimore 21223

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

x

1555D
2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND #4 & 23b PER MD. G775 9-2-99 J.A.

99 24477

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | | |
|--|--|--|---|---|---|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) BABY BOY MASTOOR | | 2. Date of Death Month Day Year July 22 1999 | | 3. Time of Death 15:37 | | | | | | | |
| 4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | | | | | |
| 5. Social Security Number | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. Months Days 1 33 | 8. Date of Birth (Month, Day, Year) July 22, 1999 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Silver Spring | | 10c. City, Town or Location Silver Spring | | | | | | | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 14936 Habersham Circle | | 10f. Zip Code 20906 | | | | | | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | | | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: UNKNOWN PAKISTANI | | 15. Decedent's Education (Specify only highest grade completed) N/A Elementary/Secondary (0-12) N/A College (1-4 or 5+) | | | | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | 16b. Kind of Business/Industry N/A | | 17. Father's Name (First, Middle, Last) Adnan Hyder | | | | | | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Momina Mastoor | | 19a. Informant's Name/Relationship (Type, Print) G.B.M.C. PATHOLOGY | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 N. CHARLES ST. TOWSON, MD. 21204 | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY | | 20c. Location - City or Town, State 7/24/99 BALTO. CITY, MD. | | | | | | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility HENRY W. BENKINS & SONS CO. 4905 YORK RD. BALTO. MD 21212. | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <u>Immaturity</u> Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death 1 1/2 hours SINCE BIRTH 3 days </td> </tr> <tr> <td>b. <u>Intracranial cystic mass</u> Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table> | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Immaturity</u> Due to (or as a consequence of): | Approximate Interval Between Onset and Death 1 1/2 hours SINCE BIRTH 3 days | b. <u>Intracranial cystic mass</u> Due to (or as a consequence of): | c. _____ Due to (or as a consequence of): | d. _____ Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Immaturity</u> Due to (or as a consequence of): | Approximate Interval Between Onset and Death 1 1/2 hours SINCE BIRTH 3 days | | | | | | | | | |
| | b. <u>Intracranial cystic mass</u> Due to (or as a consequence of): | | | | | | | | | | |
| | c. _____ Due to (or as a consequence of): | | | | | | | | | | |
| | d. _____ Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D36226 | | 29d. Date signed (Month, Day, Year) 7/23/99 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca A. Ludwig, M.D., Greater Baltimore Medical Center, 6701 N. Charles St. 21204 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature | | | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#19a perFH G774 8/4/99 EW

Certificate of Death

Reg. No.

99 24478

| | | | | | | | | | |
|---|---|---|---|---------------------------------------|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CLARICE MC MILLION | | | | 2. Date of Death Month July Day 31 Year 1999 | | 3. Time of Death 12:09 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Bayview Med Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 218-18-8462 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) 01 14 24 | | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) M.D. | | 10a. State MD | | 10b. County NA | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 124 West Franklin Street | | | | 10f. Zip Code 21201 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade | | College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Home | | |
| | 17. Father's Name (First, Middle, Last) John Green | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edith Brooks | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Romaine Harris Grand Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6520 Eberle Drive apt 102, Balto Md 21215 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | Date 8/6/99 | | 20c. Location - City or Town, State Randallstown MD | | |
| | 21. Signature of Funeral Service Licensee Gabriele Cook | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| | 23b. Dld tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) CARDIAC ARREST | | | | Approximate Interval Between Onset and Death 10 MINUTES | | | | |
| | Due to (or as a consequence of): SEPSIS | | | | 24 HOURS | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE VENTILATOR DEPENDENT | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Lu A. Diaz | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) July 31, 1999 | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUIS A. DIAZ, MD JOHNS HOPKINS HOSPITAL, BALTIMORE, MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

CONFIDENTIAL

EXHIBIT

100-100000

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

99-4358-510

CASHEY PATE

ASP

AMEND ITEMS: #23 PART I, II PER MEO G774 8-17-99 WP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24479

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Cashey Wendy Pate | | 2. Date of Death Month Day Year JULY 24 1999 | | 3. Time of Death 7:18 A | |
| 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| 5. Social Security Number N/A | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 0 Yrs. | |
| 8. Date of Birth (Month, Day, Year) JUNE 30, 1999 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 1722 Montpelier St. | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: African-American | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) infant | | 16b. Kind of Business/Industry infant | |
| 17. Father's Name (First, Middle, Last) Clarence E. Pate | | 18. Mother's Name (First, Middle, Maiden Surname) Erika McCray | | | |
| 19a. Informant's Name/Relationship (Type, Print) Erika McCray - mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 Montpelier St., Balto., Md. 21218 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk. | | 20c. Location - City or Town, State Elkridge, Md. | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. SUDDEN INFANT DEATH SYNDROME (SIDS)</p> <p>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) JULY 24, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature  | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24480

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Prestina Patricia Phillips

2. Date of Death

August 3, 1999

3. Time of Death

1:30 P.M.

4a. Facility Name (If not institution, give street and number)

9 Jill Ct.

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-48-3997

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 27, 1944

9. Birthplace (State or Foreign Country)

Baltimore, Md

Usual Residence of Decedent

10a. State

Md.

10b. County

Queen Anne's

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

104 Touhey Drive

10f. Zip Code

21666

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
+2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Social Security Adm.

16b. Kind of Business/Industry

Federal Gov't

17. Father's Name (First, Middle, Last)

Preston Harry Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gatley

19a. Informant's Name/Relationship (Type, Print)

John M. Pollock - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 Touhey Drive Stevensville, Md. 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

Aug. 4, 1999

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Justin R. Dubeau

22. Name and Address of Facility

Eckhardt Funeral Chapel

21117

11605 Reisterstown Road Owings Mills, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Brain tumor

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Bronchitis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE CARE HOME

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Clifford Solomon MD, FACS

29c. License number

D37668

29d. Date signed (Month, Day, Year)

8/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clifford Solomon MD 600 Ridgely Ave Ste 225 Andrews, MD 21401

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

1947, January 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24481

| | | | | | | | | | |
|--|---|---------------------------------|---|--|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Eva Pursley | | | | | 2. Date of Death Month August Day 2 Year 1999 | | 3. Time of Death 8:20 AM | |
| | 4a. Facility Name (If not institution, give street and number) Church Home Hospital | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 212242577 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 05-06-1907 | | 9. Birthplace (State or Foreign Country) VA |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 626 Woodbine Avenue | | | | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) 5 Elementary/Secondary (0-12) College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Home | | |
| 17. Father's Name (First, Middle, Last) Anthony Curtis Yowell | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Brown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Pursley | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 626 Woodbine Avenue, Balto., MD 21204 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery | | | 20c. Date 8-4-99 | | 20d. Location - City or Town, State Balto., MD | |
| 21. Signature of Funeral Service Licensed <i>Thomas R. Kaczorowski</i> | | | | | 22. Name and Address of Facility Kaczorowski Funeral Home 1201 Dundalk Avenue, Balto., MD 21222 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): d. Years | | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier George E. Wicks M.D. | | | 29c. License number D41365 | | 29d. Date signed (Month, Day, Year) August 2, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George E. Wicks M.D. 100 North Broadway 21231 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24482

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dora Prince | | | | 2. Date of Death Month Day Year July 21 1999 | | | | 3. Time of Death 10 ⁰⁵ pm | |
| | 4a. Facility Name (If not institution, give street and number) Harbor Hospital Center | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 215-02-2156 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) July 1, 1923 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 1213 Light Street | | | | 10f. Zip Code 21230 | | | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) None College (1-4or 5+) None | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | | | 16b. Kind of Business/Industry None | | |
| 17. Father's Name (First, Middle, Last) unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Harbor Inn Convelescent Center | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1213 Light Street, Baltimore, MD 21230 | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bilateral Bacterial pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 6 days | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Ismail Bobat M.D. | | | | 29c. License number P12792 | | 29d. Date signed (Month, Day, Year) July 21, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ISMAIL BOBAT 3001 S. HANOVER ST. BALTIMORE, MD 21225 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature Genevieve B. Sparks | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

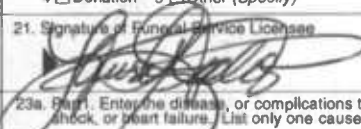
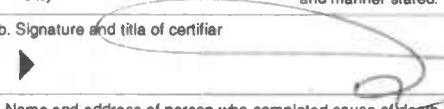
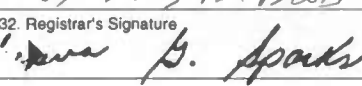
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24483

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|---|---|----|---|---|----|----------------------------------|----|----------------------------------|----|----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lillian Marie Reich | | | | 2. Date of Death Month Day Year JULY 29, 1999 | | | | 3. Time of Death 8:55 PM | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 212-01-4649 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 9, 1920 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number 3549 Horton Avenue | | | | 10f. Zip Code 21225 | | | | 10g. Citizen of What Country? USA | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | | | 16b. Kind of Business/Industry Own Home | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Harry McCabe | | | | 18. Mother's Name (First, Middle, Maiden Surname) Katie (Unobtainable) | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gordon Reich - son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6395 Loudon Avenue, Elkridge, Md. 21075 | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | Date 8/02/99 | | 20c. Location - City or Town, State Elkridge, Md. | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. 21075 | | | | | | | | | | | | | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Cancer of Lung - Metastatic Terminal Hospice</td> <td rowspan="4"> Approximate Interval Between Onset and Death > 1yr </td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Cancer of Lung - Metastatic Terminal Hospice | Approximate Interval Between Onset and Death > 1yr | b. | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | d. | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Cancer of Lung - Metastatic Terminal Hospice | Approximate Interval Between Onset and Death > 1yr | | | | | | | | | | | | | | | | |
| | b. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| | c. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| | d. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D14221 | | 29d. Date signed (Month, Day, Year) 7.30.99 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T.A. Kozlowski 223 E. Blvd BALT MD 21221 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24484

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Mary Ann Robinson

2. Date of Death
Month Day Year

August 2 1999

3. Time of Death

11:03 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice @ Mercy Hospital Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

5. Social Security Number

185-28-9878

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC 21, 1925

9. Birthplace (State or Foreign Country)

District of Columbia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

524 N. Charles Street

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

William Mathias Benezett

18. Mother's Name (First, Middle, Maiden Surname)

Emma May Richardson

19a. Informant's Name/Relationship (Type, Print)

Anne W. Kersey/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

162 Factory Mill Rd. Bumpass, VA 23024

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 08/03/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *metastatic Lung Cancer*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) *STELLA MARIS AT MERCY HOSPICE*

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Thuy M.

29c. License number

D 40854

29d. Date signed (Month, Day, Year)

August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG 301 ST PAUL PL, BALTIMORE, MD 21202

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24485

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Eileen J. Sadecki</i> | | | | 2. Date of Death Month <i>August</i> Day <i>3</i> Year <i>1999</i> | | 3. Time of Death <i>8:50 pm</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>3735 Oak Avenue</i> | | | | 4b. City, Town, or Location of Death <i>Woodlawn</i> | | 4c. County of Death <i>Baltimore</i> | |
| Funeral Director | 5. Social Security Number <i>213-68-4311</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>46</i> Yrs. | If Under 1 Year Months | If Under 24 Hrs. Days | 8. Date of Birth Month, Day, Year <i>June 20, 1953</i> | 9. Birthplace (State or Foreign Country) <i>MD</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <i>MD</i> | | 10b. County <i>Baltimore</i> | | 10c. City, Town or Location <i>Woodlawn</i> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number <i>3735 Oak Avenue</i> | | | | 10f. Zip Code <i>21207</i> | | 10g. Citizen of What Country? <i>USA</i> | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>0</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i> | | 16b. Kind of Business/Industry <i>Landscape</i> | | |
| 17. Father's Name (First, Middle, Last) <i>JNR</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>UNK</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Gloria Scott Care Provider</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3735 Oak Avenue Woodlawn, MD</i> | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Western Star</i> | | 20c. Date <i>8-11-99</i> | | 20d. Location - City or Town, State <i>Catonsville, MD 21207</i> | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility <i>Deport & Wylie Funeral Home PA 638 N. Euston St. Baltimore, MD 21201</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Squamous cell cancer of hypopharynx</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i> | | | | | | | | Approximate Interval Between Onset and Death <i>1 yr.</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature] MD</i> | | 29c. License number <i>D40850</i> | | 29d. Date signed (Month, Day, Year) <i>August 4, 1999</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>YVONNE OTTAVIANO MD 900 CATON AVE BALTIMORE MD 21229</i> | | | | | | | | |
| 31. Date of Death (Month, Day, Year) <i>AUG 04 1999</i> | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

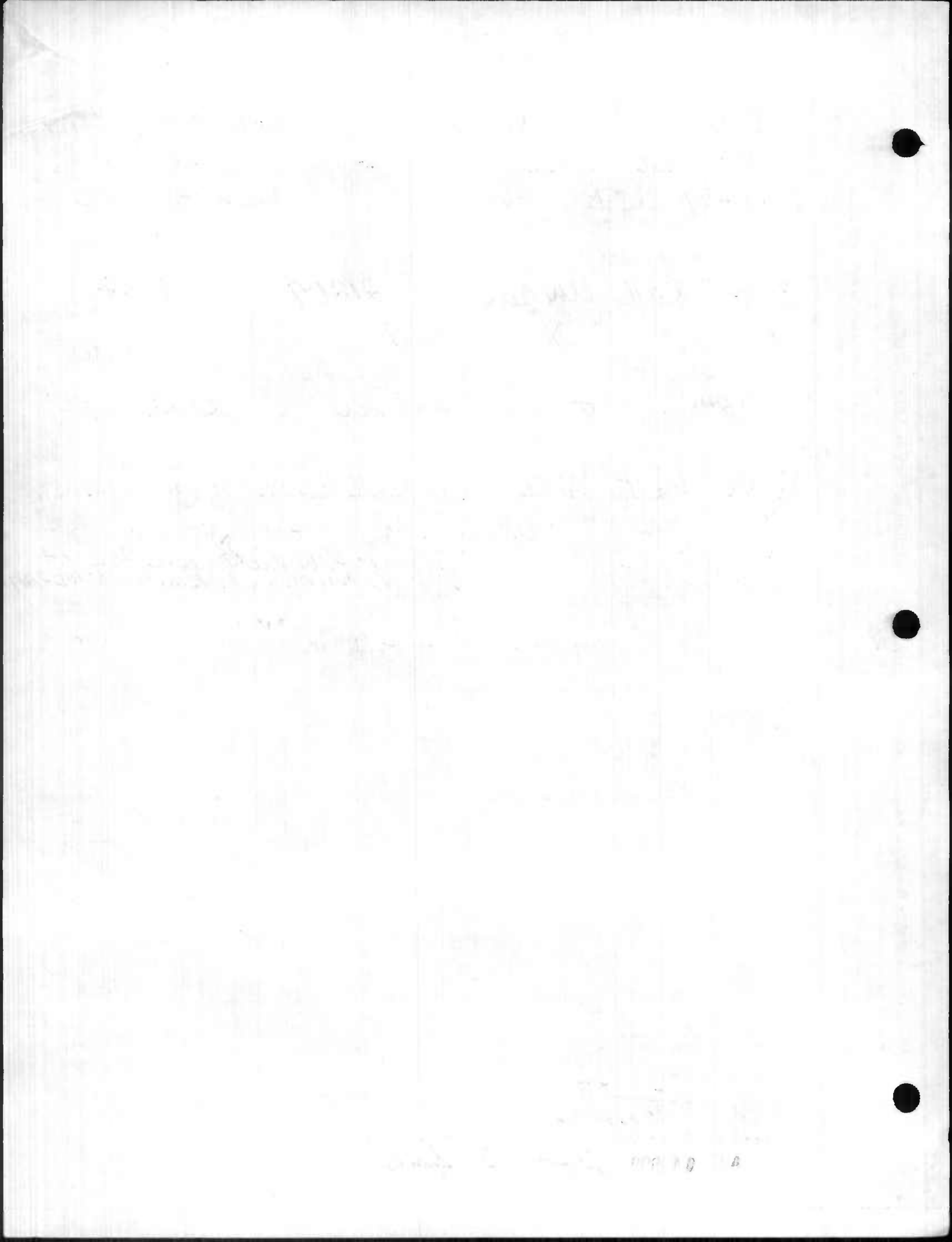
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24486

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Esther O. Shupp | | | | 2. Date of Death Month July Day 29 Year 1999 | | 3. Time of Death 9 AM | |
| | 4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital | | | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 216-32-4678 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 95 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Hours Min. | 8. Date of Birth (Month, Day, Year) May 25, 1904 | 9. Birthplace (State or Foreign Country) Wisconsin |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Prince Georges | | 10c. City, Town or Location Laurel | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 14200 Laurel Park Drive | | | | 10f. Zip Code 20707 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laundry Department | | 18b. Kind of Business/Industry Nursing Home | | |
| 17. Father's Name (First, Middle, Last) Otto Ostrich | | | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes UNK. | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Helen E. North/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2830 NE 43rd St. Ocala, FL 34479 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | Date 8/2/99 | | 20c. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac arrest Due to (or as a consequence of): Coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last History of cerebral vascular accident | | | | | | Approximate Interval Between Onset and Death Minutes Years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of cerebral vascular accident | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Timothy P. McClain MD | | | | 29c. License number D39532 | | 29d. Date signed (Month, Day, Year) 7/30/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy P. McClain 321 Prince George St. Laurel, MD 20707 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | | 32. Registrar's Signature Bernice B. Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1918

August

1918

X

1918

1918

1918

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24487

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CARL EUGENE STAPP

2. Date of Death

Month

Day

Year

JULY 31, 1999

3. Time of Death

8:15 PM.

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

257 46 0435

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

FEB 17, 1933

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

JOPPATOWNE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

203 KANE COURT

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

EXECUTIVE UNDERWRITER

16b. Kind of Business/Industry

HARTFORD INSURANCE

17. Father's Name (First, Middle, Last)

CARL O. STAPP

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Sue McGiboney

19e. Informant's Name/Relationship (Type, Print)

DORIS H. STAPP

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

203 KANE COURT JOPPATOWNE, MARYLAND 21085

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL - BELAIR, P.A.

Date

AUG 2

1999

20c. Location - City or Town, State

FOREST HILL MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS FUNERAL CHAPEL - BELAIR, P.A. 21085

3 NEWPORT DRIVE FOREST HILL MARYLAND

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Pancreatic Cancer

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Renal Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Non Insulin Dependent Diabetes

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

053627

29d. Date signed (Month, Day, Year)

JULY 31, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. V. Y. POLOTSKY 143 WIMBLEDON LANE OWINGS MILLS, MARYLAND

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24488

| | | | | | | | | | | | |
|---|---|---------------------------------|---|---|---|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWARD E. SCHLEIGH | | | | | | 2. Date of Death Month Day Year AUG. 2 1999 | | 3. Time of Death 3:02 PM | | |
| | 4a. Facility Name (If not institution, give street and number) ST. JOSEPH MEDICAL CENTER / E.R. | | | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 215-10-5683 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) DEC 16, 1917 | | 9. Birthplace (State or Foreign Country) MD. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location PARKVILLE | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 8917 EMLA AVE. | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: ARMY | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE | | | 16b. Kind of Business/Industry GENERAL MOTORS | | | | |
| 17. Father's Name (First, Middle, Last) EDWARD SCHLEIGH | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH C. ENGLEBRECHT | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARY SCHLEIGH / SPOUSE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8917 EMLA AVE. PARKVILLE, MD. 21234 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MORELAND MEM. PARK | | 20c. Location - City or Town, State PARKVILLE, MD. | | 20d. Date AUG. 5, 1999 | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility EVANS FUNERAL CHAPEL 8300 HARFORD RD. PARKVILLE, MD. 21234 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Uro sepsis Due to (or as a consequence of): b. CVA Due to (or as a consequence of): c. CAD Due to (or as a consequence of): d. MTN | | | | | | | | | | Approximate Interval Between Onset and Death 2 d yrs yrs yrs | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier  | | | | 29c. License number D43172 | | 29d. Date signed (Month, Day, Year) August 3, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9512 Harford Rd Baltimore, MD 21234, Lise Satterfield MD. | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

jhm
GLADYS
SMITH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24489

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys Smith

2. Date of Death
Month Day Year
JULY 17, 19993. Time of Death
09:29 AM

4a. Facility Name (If not institution, give street and number)

2100 PARK AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

unknown

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

unknown

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State
Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2100 Park Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

unknown

11. Marital Status unknown

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces unknown

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

unknown

1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (14 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore St.

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► M. S. Wade, Director

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. S. Wade, P. K. Wade

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

B. S. Wade

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24490

| | | | | | | | | | | | |
|--|---|--------------------------|---|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lula Mae Thomas | | | | | | 2. Date of Death Month Aug. Day 01 Year 99 | | 3. Time of Death 11:10am | | |
| | 4a. Facility Name (If not institution, give street and number) 3221 Shannon Drive | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | | |
| Funeral Director | 5. Social Security Number 212-22-8497 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) 07-16-15 | | 9. Birthplace (State or Foreign Country) NC | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 3221 Shannon Drive | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping | | | 16b. Kind of Business/Industry Wesley N.H. | | | | |
| 17. Father's Name (First, Middle, Last) Willie Thomas | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Della Ingram | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Margaret T. King | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3706 Pinkney Road Baltimore, Maryland 21215 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens | | 20c. Location - City or Town, State 08-05-99 Dundalk, MD | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility WM.C. March FH 1101 E. North Avenue 1101 E. North Avenue Baltimore, MD 21202 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number D0053124 | | 29d. Date signed (Month, Day, Year) August 3, 1998 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Bayview Circle, Baltimore MD 21224 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24491

| | | | | | | | | | | |
|--|--|--------------------------|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Vivian E. Tongue | | | | 2. Date of Death Month Day Year July 23, 1999 | | | | 3. Time of Death 3:25 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 212-20-0202 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) 05-09-23 | | 9. Birthplace (State or Foreign Country) PA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10a. Street and Number 503 Robert Street | | | | 10f. Zip Code 21217 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | | 16b. Kind of Business/Industry Domino Sugar Co. | | |
| 17. Father's Name (First, Middle, Last) Unknown | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie Fairfax | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Augusta Williams | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 Winchester Street Baltimore, MD. 21217 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens | | Date 08-05-99 | | 20c. Location - City or Town, State Dundalk, MD | | | |
| 21. Signature of Funeral Service Licensee <i>H. Valencia Holland</i> | | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lactic Acidosis Due to (or as a consequence of): b. Hepatic Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier <i>Scott Reeder</i> | | | | 29c. License number P13217 | | 29d. Date signed (Month, Day, Year) July 27, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Reeder, MD, PhD, 2401 W. Belvedere Ave, Baltimore, MD 21215-5271 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | 32. Registrar's Signature <i>G. Sparks</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24492

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nadine B. Tamres

2. Date of Death

Month Day Year
July 30 1999

3. Time of Death

11:10pm

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

224-24-6189

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 6, 1926

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2108 Cider Mill Rd.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

James A. Slusker

18. Mother's Name (First, Middle, Maiden Surname)

Clara V. Peedue

19a. Informant's Name/Relationship (Type, Print)

Morris M. Tamres

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2108 Cider Mill Rd. Baltimore, Md 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gdns

Date

Aug 2 1999

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Heister J. Wells

22. Name and Address of Facility

EVANS Funeral Chapel
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. coronary artery disease

Due to (or as a consequence of):

years

c. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

decades

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Huaibin Li, MD

29c. License number

P11827

29d. Date signed (Month, Day, Year)

7/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huaibin Li, MD, ste 203, 6565 N. Charles St, Baltimore, MD 21204

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

Laura B. Sparks

State
Registrar

Tamres, Nadine
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

753119

0001 11/11/11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24493

| | | | | | | | | | |
|--|--|--|--|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) MARGARET H. VANDEGRIFT | | | | 2. Date of Death Month AUGUST Day 1 Year 1999 | | 3. Time of Death 3:05 PM | | |
| | 4a. Facility Name (If not institution, give street and number) HOLLY HILL MANOR NURSING HOME | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 244-10-6630 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 08-24-1910 | 9. Birthplace (State or Foreign Country) DELAWARE | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State MD. | | 10b. County BALTIMORE | | 10c. City, Town or Location TOWSON | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 531 STEVENSON LANE | | | | 10f. Zip Code 21286 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 YEARS Collage (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REGISTERED NURSE | | 16b. Kind of Business/Industry HEALTH CARE | | | |
| 17. Father's Name (First, Middle, Last) JOHN M. HANSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) MAUDE ROWE | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JOHN A. BALDWIN (NEPHEW) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2032 FERRY FARMS RD., ANNAPOLAS, MD., 21402 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY 8-3 | | Date BALTO., MD., 21202 | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e. <u>pneumonia</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | Approximate Interval Between Onset and Death 7 days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>dementia, osteoporosis</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D41104 | | 29d. Date signed (Month, Day, Year) AUGUST 3, 1999 | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) THEODORE C. HOUK, M.D., 7825 YORK ROAD, TOWSON, MARYLAND, 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

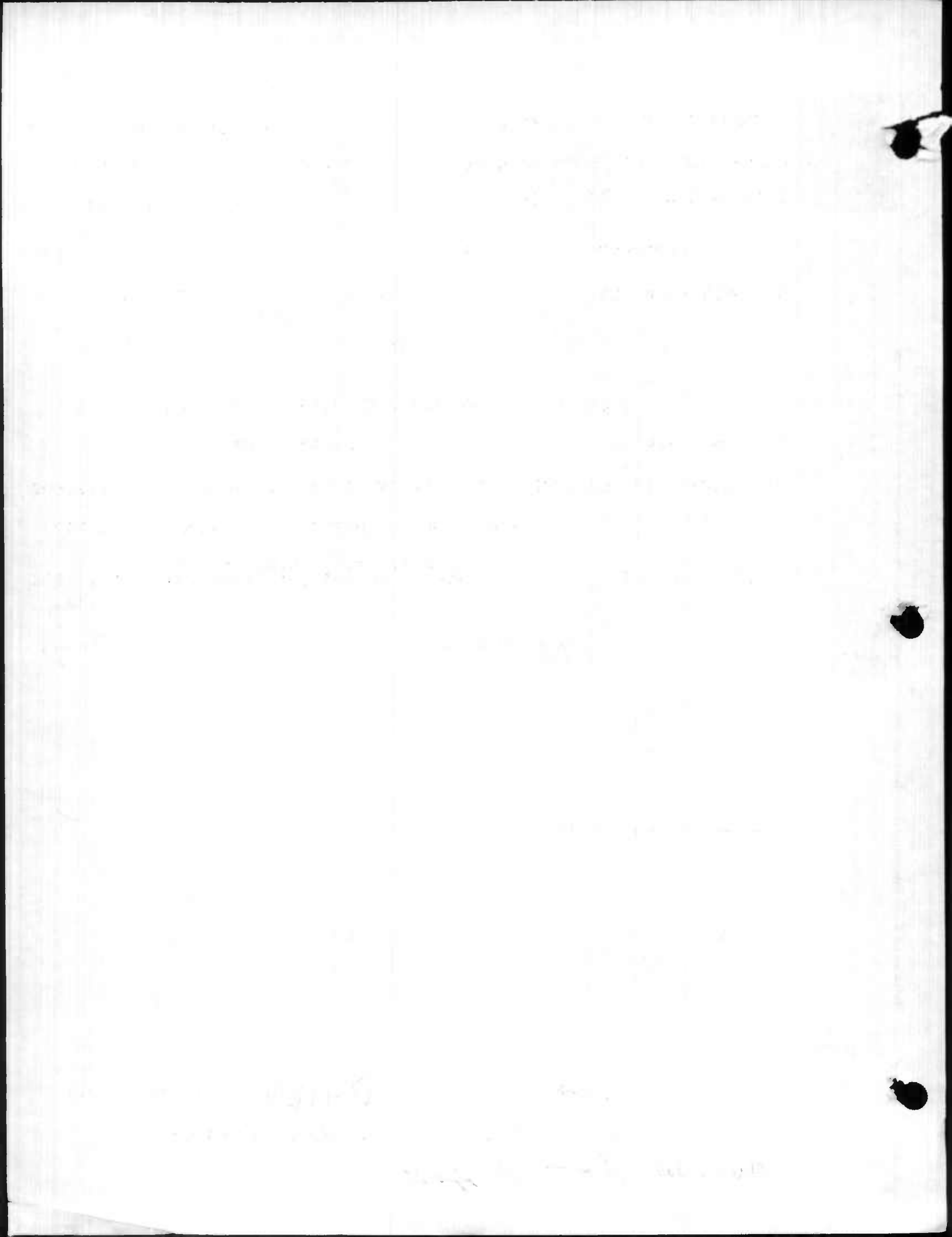
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



VOID

CERTIFICATE #

99-24494

SEE

FETAL

CERTIFICATE #

99-00279

PPPPA PP

JAT97

PTA00 PD

Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 24495

| | | | | | | | | | |
|--|---|--|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edith WISE | | | | 2. Date of Death Month Day Year July 30, 1999 | | 3. Time of Death 2:20 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 212-32-2737 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 96 Yrs. | | 8. Date of Birth (Month, Day, Year) 8-29-03 | | |
| | 9. Birthplace (State or Foreign Country) SOUTH CAROLINA | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1734 E. PRESTON ST | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (14 or 5+) Collega (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED | | 16b. Kind of Business/Industry DOMESTIC | | 17. Father's Name (First, Middle, Last) UNKNOWN | | 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN | |
| 19a. Informant's Name/Relationship (Type, Print) JAMES SMITH (SON) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 ST. STEVENSON CT A1, BALTO. MD 21216 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) metro crematory | | 20c. Location - City or Town, State 8-4-99 BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Stage III-IV Sacral decubitus Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number 98021 | |
| 29d. Data signed (Month, Day, Year) July 30, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irene Browner Johns Hopkins Bayview Medical Center, Baltimore, MD 21224 | | 31. Data filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

AM!

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24496

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert J. Washington Jr.

2. Date of Death

August 2, 1999

3. Time of Death

16:42 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-44-8963

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 24, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland

N/A

10a. State

Baltimore

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

4709 Maryknoll Rd.

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1X Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Robert J. Washington Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Armalene Howard

19a. Informant's Name/Relationship (Type, Print)

Mrs. Carolyn Wells (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4709 Maryknoll Rd. Balto. Md. 21208

20a. Method of Disposition

1X Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park 8/7/99 Balto. Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Multi-organ System Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Lactic Acidosis

Due to (or as a consequence of):

d. pneumonia

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, peripheral vascular disease, COPD

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 4X Unknown

24a. Was an autopsy performed?

10 Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 2X No

25. Was case referred to medical examiner?

10 Yes 2X No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

1X Natural 50 Pending Investigation
20 Accident 60 Could not be determined
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

10X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Resident physician

29c. License number

RES-001

29d. Date signed (Month, Day, Year)

August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William E. Kulke, MD, Sinai Hospital, Baltimore, MD 21215

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24497

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSALIE A. WINDSOR

2. Date of Death

Month 7 Day 27 Year 99

3. Time of Death

6.30A

4a. Facility Name (If not institution, give street and number)

KESWICK MULTICARE 700 W. 40th St

4b. City, Town, or Location of Death

BALTO., MD

4c. County of Death

N/A

5. Social Security Number

212-05-1876

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 YRS

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
01-08-1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

141 EAST WEST ST.

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 YRS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER-TELEPHONE CO.

16b. Kind of Business/Industry

TELEPHONE CO.

17. Father's Name (First, Middle, Last)

FREDERICK REINHART

18. Mother's Name (First, Middle, Maiden Surname)

KATHERINE SCHWERMANN

19a. Informant's Name/Relationship (Type, Print)

ROGER M. WINDSOR (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4023 DEEPWOOD RD. BALTO., MD. 21218.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREEN MOUNT CREMATORY

Date

07/28/99

20c. Location - City or Town, State

BALTO., MD.

21. Signature of Funeral Service Licensee

William C. Lawrence

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic Cardiomyopathy

Due to (or as a consequence of):

unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Isabelle MacGregor MD

29c. License number

D13657

29d. Date signed (Month, Day, Year)

July 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. ISABELLE MACGREGOR, KESWICK, 700 W. 40th STREET, BALTIMORE, MD 21211

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

Benjamin B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

James A. Smith

COPIED BY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24498

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth Winter

2. Date of Death

07 29 1999

3. Time of Death

12:15pm

4a. Facility Name (If not Institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-05-4813

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
2-28-1919

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4318 LaSalle Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward Eichelman

18. Mother's Name (First, Middle, Maiden Surname)

Christine Shrufer

19a. Informant's Name/Relationship (Type, Print)

William J. Winter Sr.-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4318 La Salle Ave. Baltimore, Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

8-2-1999

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Mary R. DiGiovanni

22. Name and Address of Facility

Leonard J. Ruck Funeral Home

5305 Harford Rd. Baltimore, Md. 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Chronic long disease

Approximate Interval Between Onset and Death

4 years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic heart disease

Respiratory failure

Alcohol

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Eddie Nakhuda

29c. License number

115504

29d. Date signed (Month, Day, Year)

9-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Eddie Nakhuda 2300 Dulaney Valley Rd. Timonium, Md. 21093

31. Date filed (Month, Day, Year)

AUG 04 1999

32. Registrar's Signature

James G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Winter, Mary

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24499

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) ANN THERESA ALEXANDER | | | | 2. Date of Death Month Day Year July 19, 1999 | | 3. Time of Death 9:10 AM | |
| 4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| 5. Social Security Number 577-20-0300 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 | | 8. Date of Birth (Month, Day, Year) October 16, 1921 | |
| 9. Birthplace (State or Foreign Country) Washington, D.C. | | 10a. State Maryland | | 10b. County Queen Anne | | 10c. City, Town or Location Stevensville | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 107 Monoponsan Drive | | 10f. Zip Code 21666 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Collega | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant | | 16b. Kind of Business/Industry U.S. Gov't. | | | |
| 17. Father's Name (First, Middle, Last) Hayden Graves | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Morris | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sandra Alexander | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Monoponsan Drive, Stevensville, MD 21666 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Location - City or Town, State Suitland, MD | | 20d. Date 7/24/99 | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave., Suitland, MD 20746 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sacral Decubitus Ulcer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Anorexia Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death 1M 3M | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number 032036 | | 29d. Date signed (Month, Day, Year) 7/19/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary J. Spruse 2108 P. Danahy Drive Chester, MD 21619 | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 22 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

To Be Completed by Funeral Director

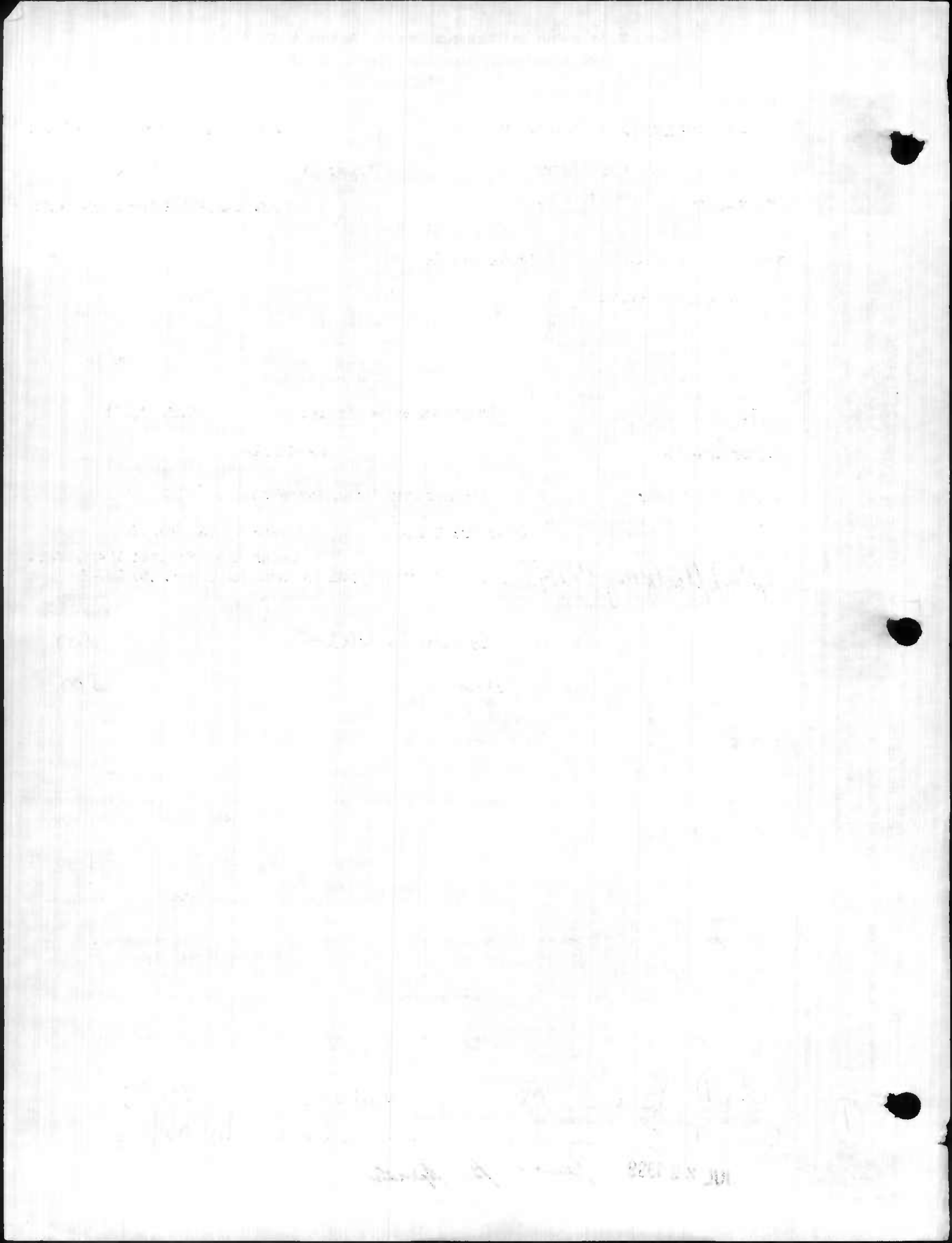
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 24500

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH AXENFELD

2. Date of Death

07 21 99

3. Time of Death

7:50 p.m.

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

578-54-1404

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs., last birthday)

00 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 24, 1932

9. Birthplace (State or Foreign Country)

Scotland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Ft. Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13117 Glasgow Way

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

George Fielding

18. Mother's Name (First, Middle, Maiden Summa)

Annie McQueen

19a. Informant's Name/Relationship (Type, Print)

Kevin Axenfeld/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9316 Kenbrooke Ct., Laurel, MD 20723

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem.

Date

7/27/1999

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.

6160 Oxon Hill Rd., Oxon Hill, Md 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatorenal syndrome

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. cirrhosis

Due to (or as a consequence of):

Yrs

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

29c. License number

29d. Date signed (Month, Day, Year)

7/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklin P. P. MD, 11701 Livingston Rd #203 FT. WASH MD 20744

State Registrar

31. Date filed (Month, Day, Year)

JUL 23 1999

32. Registrar's Signature

33. Signature of Physician/Medical Examiner

ORIGINAL

Axenfeld, Elizabeth
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

10

